

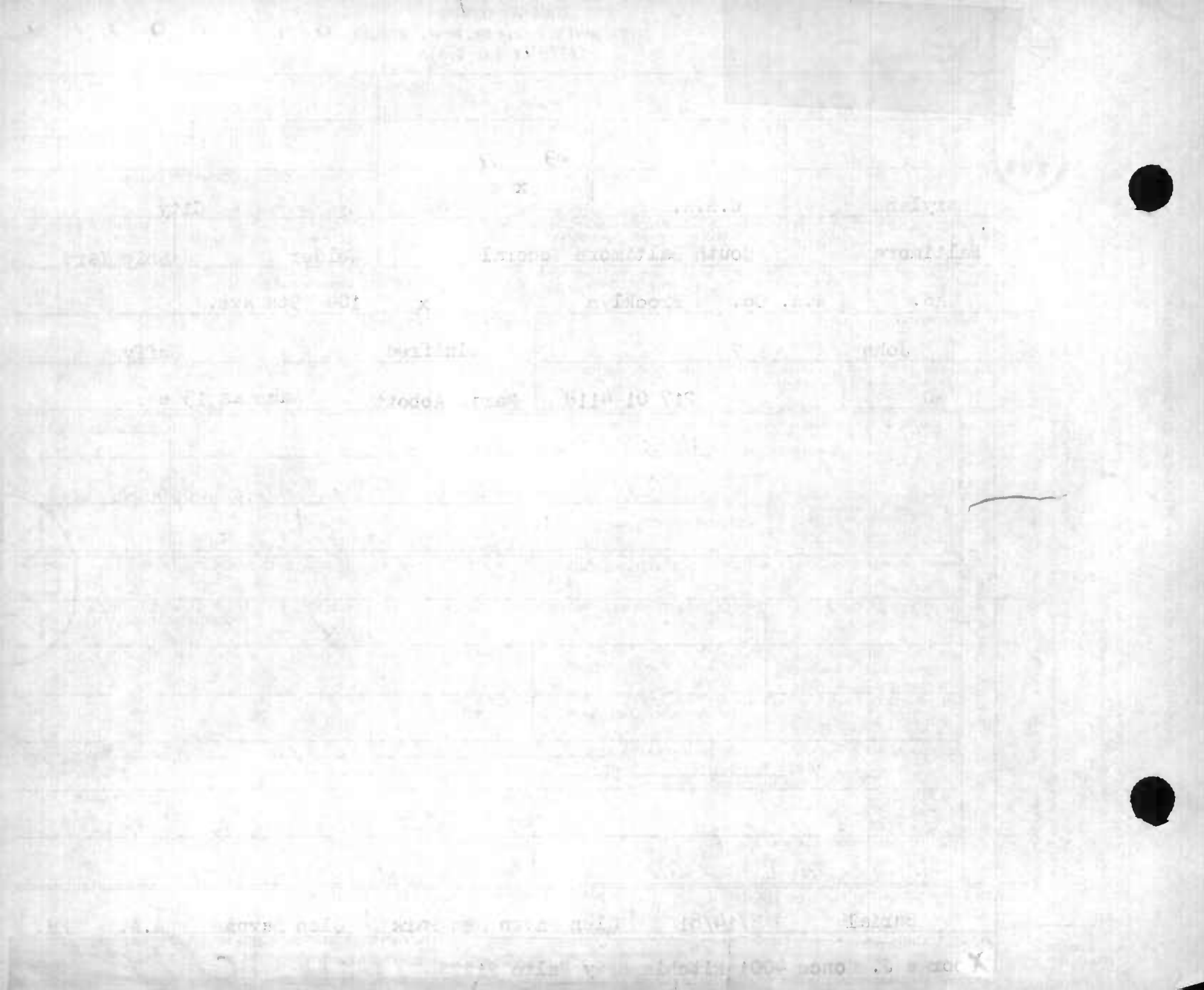
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTIN A ABBOTT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>March 11 81</b>		2b. HOUR <b>7:50 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 11 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. CITY OR TOWN <b>A.A. Co.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET ADDRESS <b>104 9th Ave.</b>				14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Winifred Duffy</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>217 01 4118</b>				17. INFORMANT <b>Marie Abbott</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive pulmonary D's.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Congestive heart failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>81</b> , to <b>3/11</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Maureen L. Durkin</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/11/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAUREEN L. DURKIN</b>				22e. ADDRESS <b>South Balt. General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hwy Balto 21225</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>Robert A. Brady</b>			





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH		MONTH DAY YEAR		2c. HOUR	
		Carl F. Achatz, Sr.				3/31/81				7:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M		Cauc.		7/6/30		50 YRS		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Sinai Hosp. of Balt.		Supervisor		Baltimore City					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
md.		Balt.		Balt.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		407 Brownell Rd.		21220	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Frank		Wilhelmina									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		1952		Mrs. Joyce Achatz, 407 Brownell Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629		Cardio-respiratory arrest				metastatic cancer of lung					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from		3/16		19 81, to		3/31		19 81, that (I) (we) lost			
saw the deceased alive on		3/31		19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
J. M. Mark, MD						3/31/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE			
Burial		4/3/81		Holly Hills Mem.		Baltimore, Md.					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph N. Zannino, 263 S. Conkling St.						APR 02 1981		[Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	0	6	6	7	8			
1 - FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR			
Edward					Addleberger					March 1, 1981						5:30P M			
3. SFX		4. RACE		5. DATE OF BIRTH		6. AGE		7. BIRTHPLACE		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
Mnhy		White		10/31/1900		80		unk.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City		Baltimore		Maryland General Hospital			
7b. BIRTHPLACE		7c. CITIZEN OF WHAT COUNTRY?		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
unk.		U.S.A.		Carpenter		Retail		Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		501 W. Franklin St.			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.				
unk.					unk.					No					213-32-9607				
17. INFORMANT					ADDRESS					18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Barbara Roberts					501 W. Franklin St.					PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1, 1981, to March 1, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 1, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If <input checked="" type="checkbox"/> (we) did not view the body after death.)																			
22b. SIGNATURE					DEGREE					22c. DATE SIGNED									
Harry E. Nervino, M.D.					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					3/2/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS														
Harry E. Nervino M.D.					Care of Maryland General Hospital														
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Burial					3/4/81					Mt. Calvary					AA County Md				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
Joe Saville					1712 W. North Ave					MAR 3 1981					[Signature]				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 6 7 9

1- FOR  
STATE  
REGISTRAR

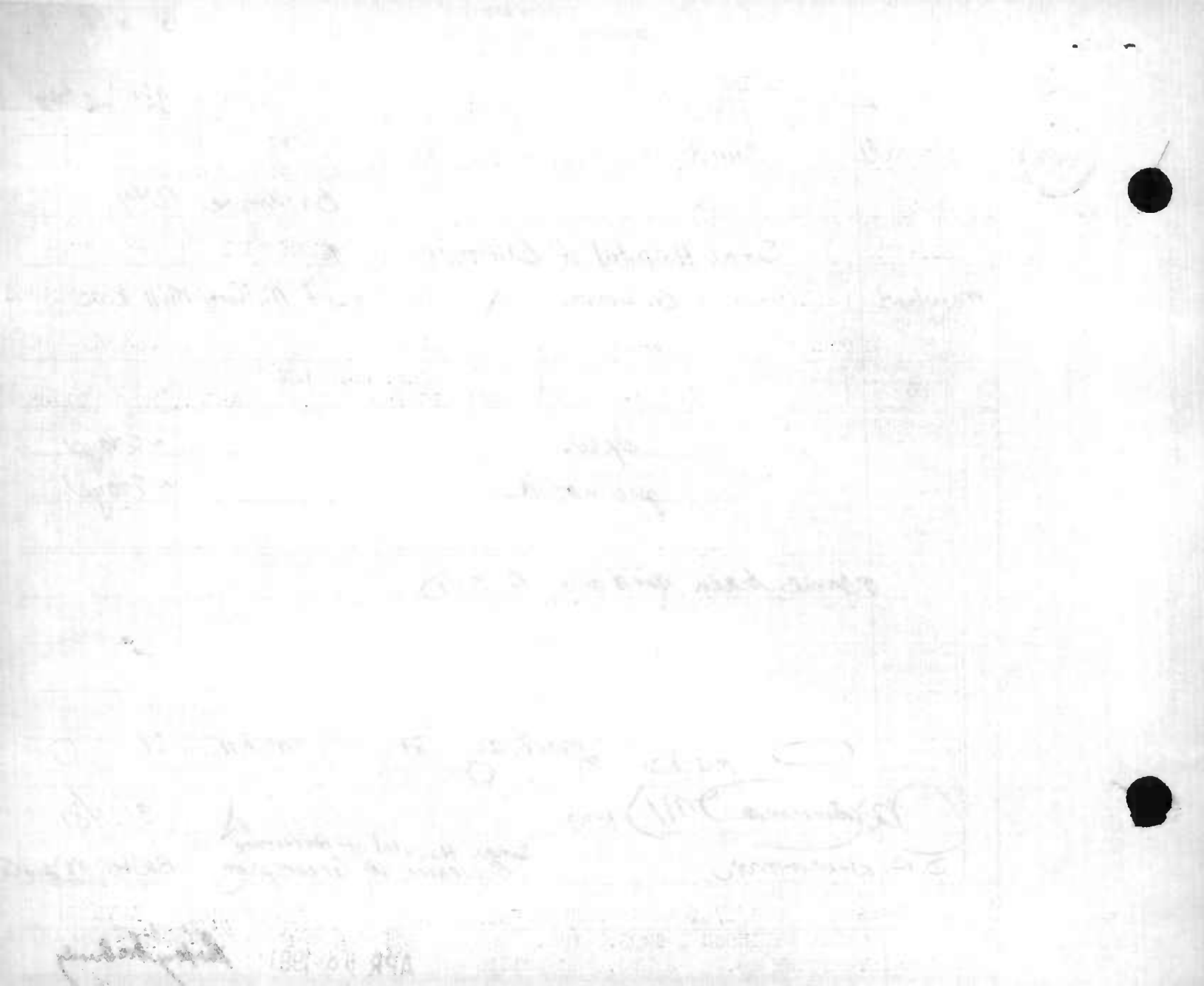
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Adler, Miriam</i>		FIRST MIDDLE LAST <i>Adler, Miriam</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>31 March, 1981</i>		2b. HOUR <i>2:30 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>August 22 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City, MD.</i>	
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital of Baltimore</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ISRAEL MOLITZ</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>RIVA UNKNOWN</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-28-1621</i>	
17. INFORMANT NAME ADDRESS <i>MRS. RUTH LEV</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>organic brain syndrome, ASCVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~ 5 days</i> <i>~ 7 days</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 25</i> , 19 <i>81</i> , to <i>March 31</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>March 31</i> , 19 <i>81</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>D.A. Kleinerman</i>		22c. DATE SIGNED <i>3/31/81</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4/1/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW FRIENDSHIP</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR <i>APR 08 1981</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 6 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Melvin Akers, Sr.</b>			2a. DATE OF DEATH MONTH <b>3</b> DAY <b>4</b> YEAR <b>81</b> 2b. HOUR <b>4:45p</b> M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>16</b> YEAR <b>10</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. MONTHS DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE MARYLAND City MD.</b>		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FRUIT &amp; PRODUCE</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>600 LIGHT ST. BALTO. MD.</b>		
14. FATHER'S NAME FIRST <b>HENRY</b> MIDDLE <b>AKERS</b> LAST			15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>Mc DONOUGH</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213 05 2251</b>	17. INFORMANT ADDRESS <b>GERTRUDE E. AKERS 600 LIGHT ST. BALTO. MD. 21230</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAL ARREST</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>MI, COPD, DIABETES MELLITUS</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-20-81</b> , 19____, to____, 19____, that (I) (we) last saw the deceased alive on <b>3-4-81</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Peter T. Lapinsky MD</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER T. LAPINSKY</b>		22e. ADDRESS <b>MOREY HOSP BALTO MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/7/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>DIPPEL FUNERAL HOMES 7110 BELAIR RD. BALTO. MD. 21206</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Peter T. Lapinsky</b>					

\* 251 20 75

340-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Mahala (Mahalia) A. ALFORD</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>March 22 1981</b>					2b. HOUR <b>11:16 P.M.</b>
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 24 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City'</b> MD.				
12. CITY OR TOWN OF DEATH <b>Baltimore</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2205 Koko Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Appy Giddias</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Wilson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-24-6096</b>		17. INFORMANT ADDRESS <b>Wayne T. Alford 2300 S. 24th Rd Apt 1031</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Cardiopulmonary Arrest</b> IMMEDIATE CAUSE (a) <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>March 22</b> , 19 <b>81</b> , to <b>March 22</b> , 19 <b>81</b> , that <b>XX</b> (we) lost saw the deceased alive on <b>March 22</b> , 19 <b>81</b> , and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>XX</b> (we) did <b>XX</b> view the body after death.										
22b. SIGNATURE <b>Joe Ganey MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>3-23-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joe Ganey, M.D.</b>					22e. ADDRESS <b>c/o Maryland General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>3/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Hope Westminster</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>					ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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March 22 1961

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Maryland General Hospital

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c/o Maryland General Hospital

Joe Gandy, M.D.

MAR 22 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PASCO LEROY ALLEN SR			2a. DATE OF DEATH MONTH DAY YEAR MARCH 20, 1981		2b. HOUR 09:15 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 4 1926	6. AGE (IN YEARS LAST BIRTHDAY) 54		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STEAM FITTER		12b. KIND OF BUSINESS OR INDUSTRY PLUMBING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Burton Allen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Elizabeth Gehler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT ADDRESS Norma Jean Allen #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>metabolic and cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Obstructive Jaundice / Dehydration</u>					
19a. DATE OF OPERATION 3/3/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bile duct obstruction - Rm. Gall. Neck		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/29/81</u> , 19 <u>81</u> , to <u>3/20</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3/20/81</u> , 19 <u>81</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Andrew Klein</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/20/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Klein		22e. ADDRESS 600 N. Wake St.			
23a. BURIAL, CREMATION, REMOVAL (BY CITY) BURIAL		23b. DATE 3/24/81		23c. NAME OF CEMETERY OR CREMATORY H. HEREST	
23d. LOCATION CITY OR TOWN HUNNAPOLIS		23e. COUNTY AA		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME John M. Sly & Son		ADDRESS Hunnepoh, Md		25. DATE REC'D. BY REGISTRAR MAR 26 1981	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT STATE: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD ALLENDER						2a. DATE OF DEATH MONTH DAY YEAR MARCH 14, 1981		2b. HOUR 11:20PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 17 1927		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		7. UNDER 24 HRS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		9. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
12. CITY OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST William Allender		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Cooper		16. ADDRESS Olivia Allender 1827 N. Milton Avenue							
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-22-2863		19. INFORMANT Olivia Allender 1827 N. Milton Avenue							
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3451 IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Grand Mal & Focal Seizure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11:20 PM 10:45 PM											
21. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Liver Failure; Right Ventricular Heart Failure											
22. DATE OF OPERATION NONE		23. CONDITION FOR WHICH OPERATION WAS PERFORMED				24. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		25. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NONE							
29. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		31. LOCATION STREET CITY OR TOWN COUNTY STATE							
32. I certify that (I) (this hospital) attended the deceased from 3/13, 1981, to 3/14, 1981, that (I) (we) last saw the deceased alive on 3/14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
33. SIGNATURE Christine Edry Seidman MD		34. DEGREE MD				35. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		36. DATE SIGNED 3/14/81			
37. PHYSICIAN'S NAME (TYPE OR PRINT) Christine Edry Seidman		38. ADDRESS 601 N Broadway - Johns Hopkins Hosp. Bldg									
39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		40. DATE 3/20/81		41. NAME OF CEMETERY OR CREMATORY Holly Hill Cem.		42. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD					
43. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave		44. ADDRESS		45. DATE REC'D. BY REGISTRAR MAR 16 1981		46. REGISTRAR'S SIGNATURE Rafael McBrady					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed at least 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 0 6 5 8 4

1. DECEASED NAME (TYPE OR PRINT) <b>ELEANOR I ALMES</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 31, 1981</b>		2b. HOUR <b>11:50A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 30, 1911</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOME &amp; HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
13a. STATE <b>MARYLAND</b>		13c. CITY OR TOWN <b>BALTO. DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XXX</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SIDNEY LISSMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE UNKNOWN</b>		13e. STREET ADDRESS <b>6836 BROENING RD. 21222</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>138-03-4867</b>		17. INFORMANT <b>ROSENBERG, RAPHAEL, SACHS FUNERAL HOME 4720 N. BROAD ST. PHILA., PA 19140</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE RECTUM WITH METASTASIS TO THE LUNG AND LIVER</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1541</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from <b>MARCH 20, 1981</b> , to <b>MARCH 31, 1981</b> , that (1) we last saw the deceased alive on <b>MARCH 31, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE <b>Y. K. SHETTY</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3-31-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Y. K. SHETTY</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MD 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>REMOVAL/BURIAL</b>		23b. DATE <b>APR. 5, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ADATH JESHURUN</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>PHILADELPHIA PA</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 08 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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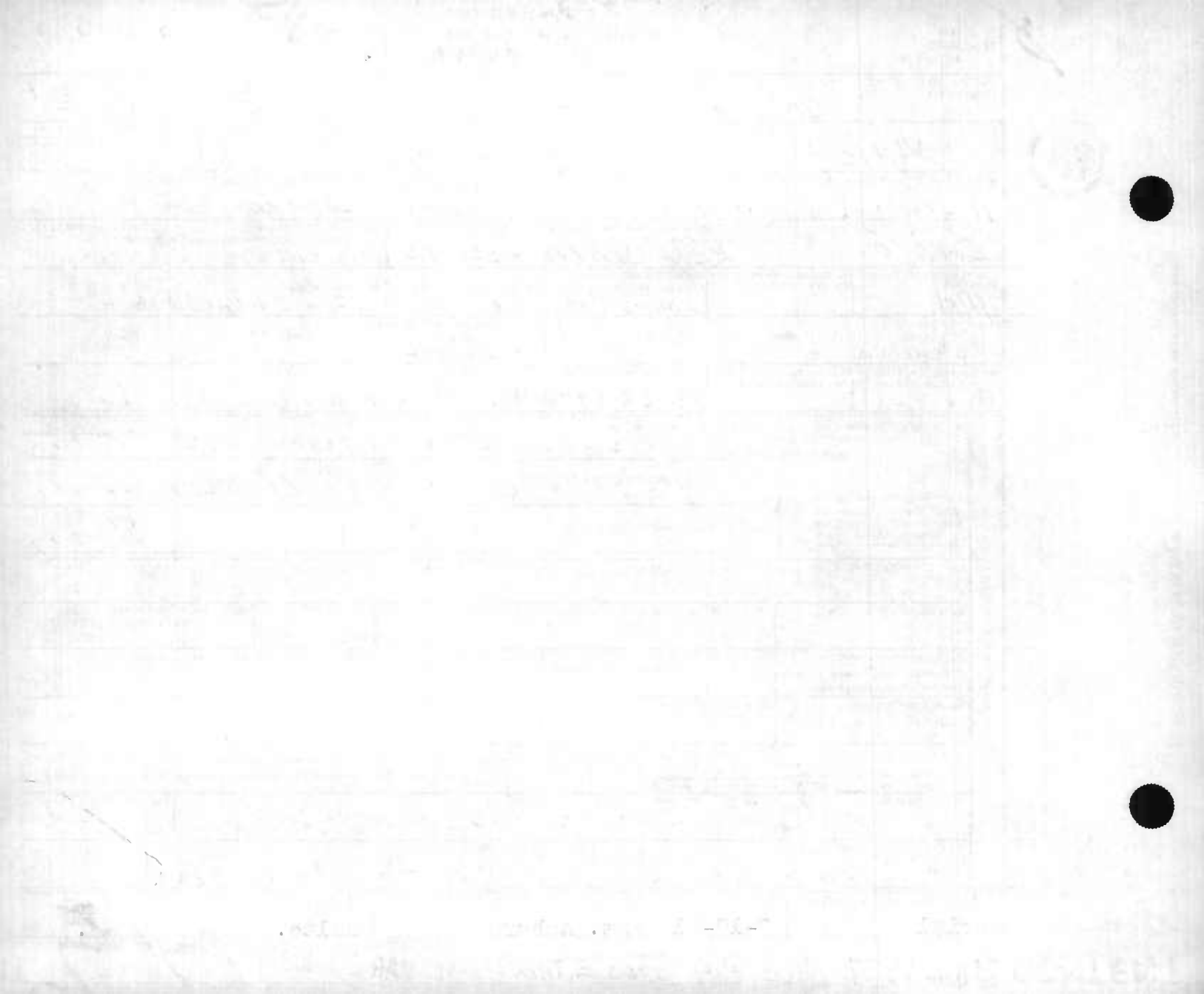
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 0 6 6 8 5			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Washington		MIDDLE		LAST Alonzo		2r. DATE OF DEATH		MONTH 3	DAY 14	YEAR 81	2b. HOUR 7:30 P M
3 SEX MALE		4 RACE Black		5. DATE OF BIRTH		MONTH 8		DAY 15		YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Circle Hospice						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Unknown			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Baltimore City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1214 Eutaw Place			
14. FATHER'S NAME FIRST Unknown				MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 332-03-9440		17. INFORMANT ADDRESS Key Circle Medical Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4439 DUE TO, OR AS A CONSEQUENCE OF (b). Cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c). ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs 15 yrs 20 yrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-13-81 to 3-14-81, that (I) (we) last saw the deceased alive on 3-13-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Richard K. Rigler				DEGREE Attending Physician				22c. DATE SIGNED 3-11-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard K. Rigler			
22e. ADDRESS 820 Staphord Road				22f. NAME OF CEMETERY OR CREMATORY Mt. Auburn				22g. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-19-81		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Charles A. Rice P.A.				ADDRESS 1300 Eutaw Pl				25a. DATE REC'D. BY REGISTRAR MAR 19 1981		25b. REGISTRAR'S SIGNATURE			





Item 8 8555 3/0/01 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 6 8 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

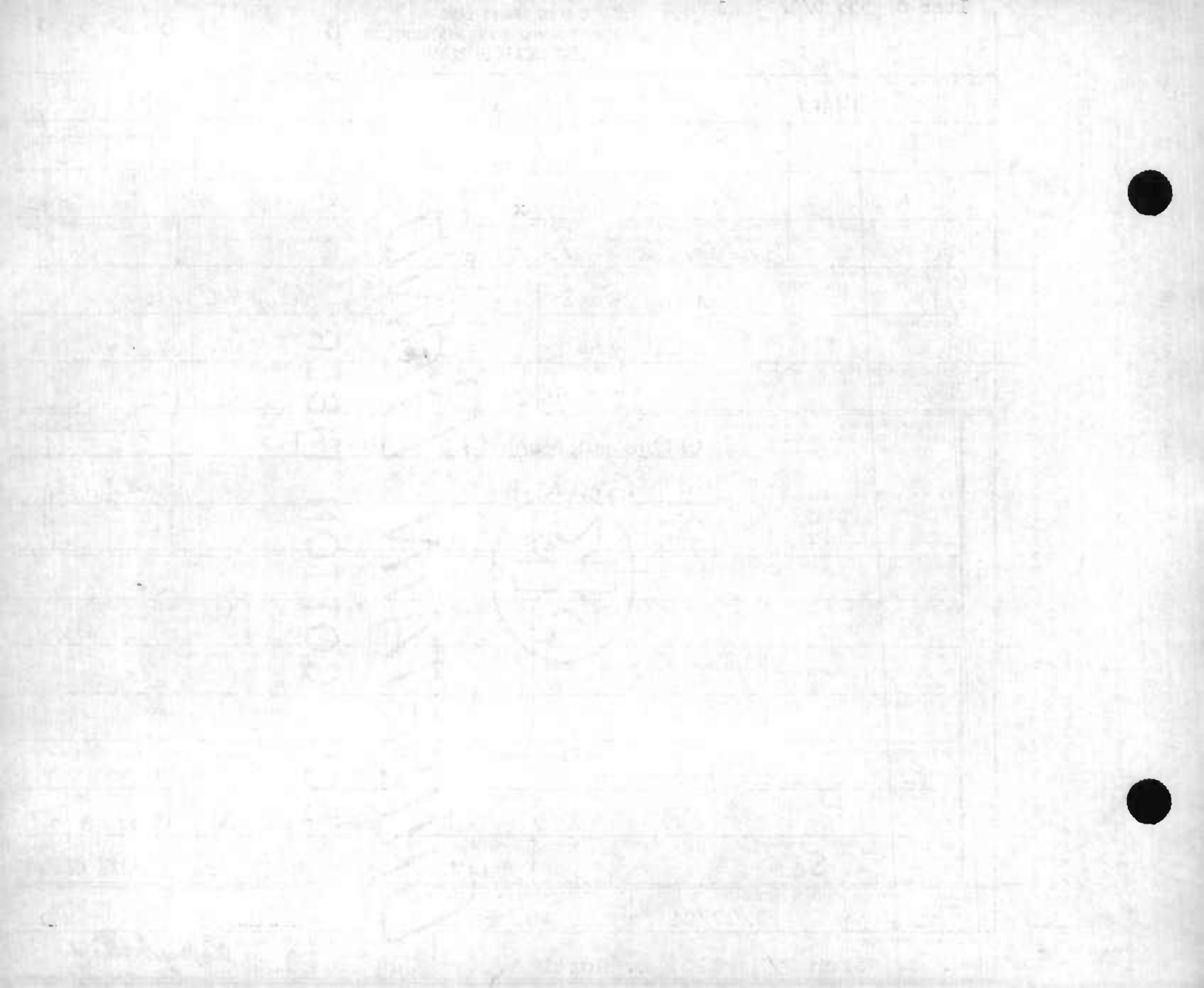
1. DECEASED NAME (TYPE OR PRINT) <b>MARY ALSTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>3 23 81</b>		2b. HOUR <b>12 57 PM</b>
3 SEX <b>F</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06-14-15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Md. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Williams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sallie Pitchforth</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-32-7405</b>		17. INFORMANT ADDRESS <b>Jim Williams 1714 Druidhill Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERKALEMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADULT ONSET DIABETES</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 2 hrs</b> <b>&lt; 1 day</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>81</b> , to <b>3/23</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/23/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>So MD</b>				22c. DATE SIGNED <b>3/23/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>So</b>				22e. ADDRESS <b>UNIV. OF MD. HOSP., 22 S GREENE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony R. Brady</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		(BENARDO)		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 0 6 6 8 7	
1. DECEASED NAME (TYPE OR PRINT)		BENARDO P. AMEDORO		CERTIFICATE OF DEATH		REG. NO.	
2a. DATE OF DEATH		MONTH DAY YEAR		3 18 81		2b. HOUR 2 <sup>00</sup> PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		white		8 11 15		65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				BALTO city MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.		The Good Samaritan Hosp.		PRINTER		NEWSPAPER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
md. BALTIMORE		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1514 customs Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
VITTORIO		AMEDORO		YES		186-034585	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
BERNADETTE CRAWFORD		8 KRISWOOD CT.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:				PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)		1629		IMMEDIATE CAUSE (a)		Respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF		8 mos	
(b)				(b)		squamous cell carcinoma - lungs	
DUE TO, OR AS A CONSEQUENCE OF				DUE TO, OR AS A CONSEQUENCE OF			
(c)				(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH		BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH		BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 16, 19 81, to March 18, 19 81, that (I) (we) lost saw the deceased alive on March 18, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Kenneth H.C. Silver MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/18/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Kenneth H.C. Silver MD		832 Evesham Avenue, Balto, Md 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		3/23/81		DULANEY VALLEY		CITY OR TOWN COUNTY STATE	
						COCKEYSVILLE BALTO. MD.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		DATE REC'D. BY REGISTRAR	
		John Wood		1211 Chesapeake Ave.		MAR 21 1981	



3

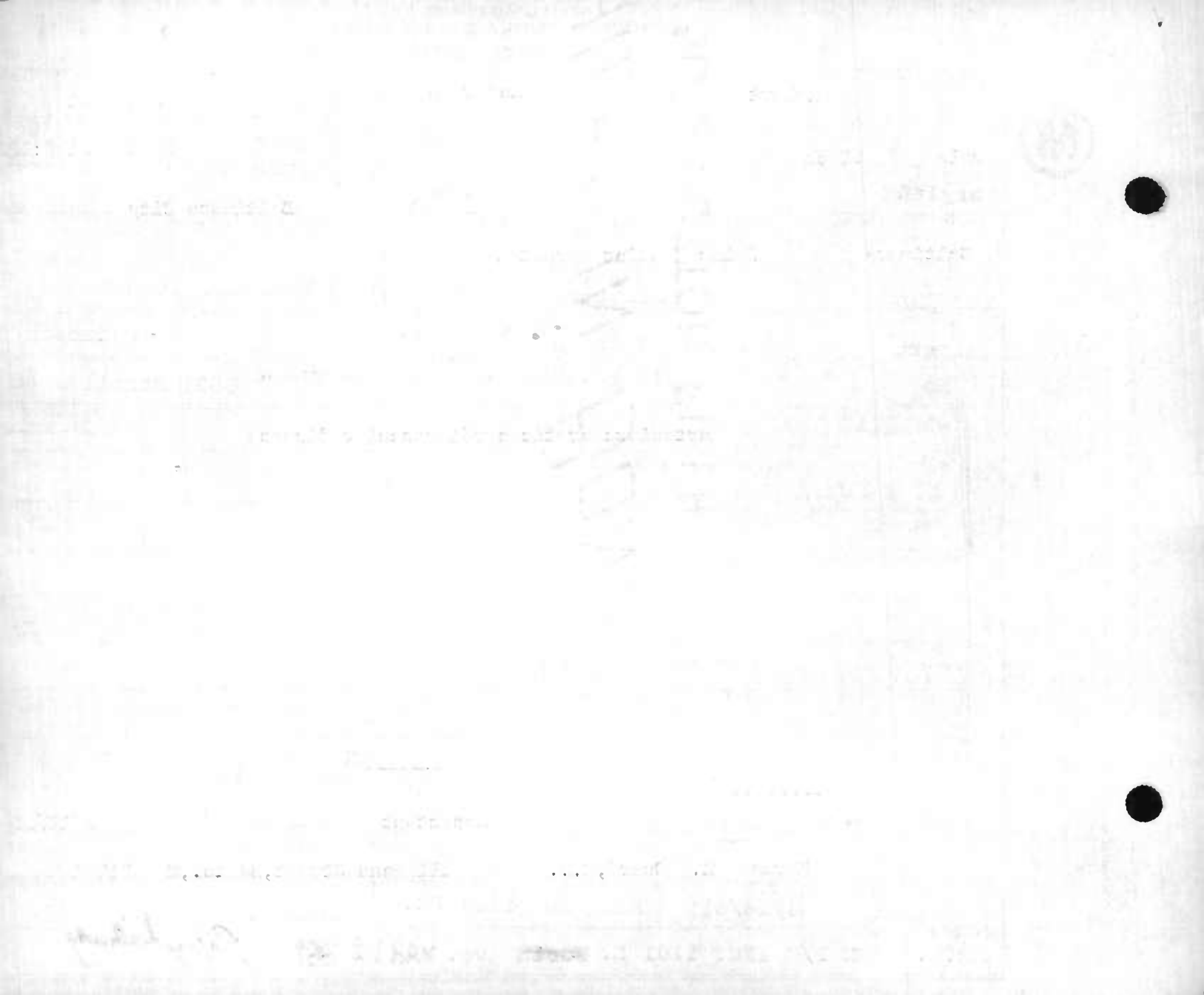
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

0833

DHMH - 17  
(VR 15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 06588	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Robert Lee Anderson Sr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 10 81</b>	
3. SEX <b>male</b> 4. RACE <b>black</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>4 9 19</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.										2c. DATE PRONOUNCED DEAD <b>3 10 81</b> 2d. HOUR <b>8:15</b> AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>1201 Montford Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert W. Quarles</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Lucille Anderson</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <b>213-18-8856</b>	
17. INFORMANT ADDRESS <b>Barbara Stevenson 5521 Sarril Road</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> IMMEDIATE CAUSE (a) <b>CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b> (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H. R. Guard</b> M.D. <b>Assistant</b> MEDICAL EXAMINER										DATE SIGNED <b>3/11/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b> ADDRESS <b>111 Penn Street, Balto., MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>3/16/81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD.</b>	
24. FUNERAL DIRECTOR NAME <b>WM.C.MARCH F/H INC.</b> ADDRESS <b>1101 E. North Ave.</b>										25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1981</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



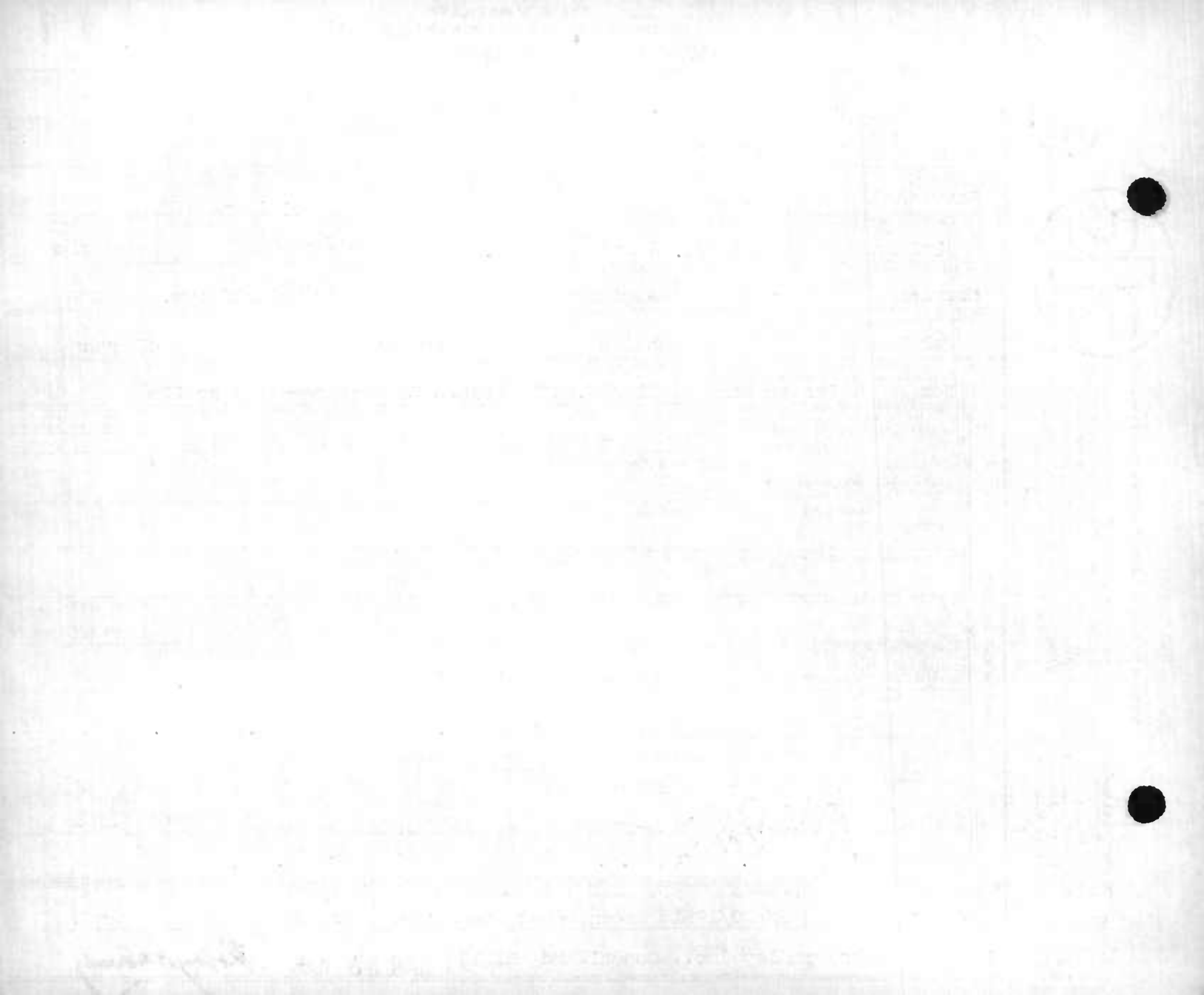


**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 8

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |                                   |  |  |  |   |  | REG. NO.  |  |
|---|--|----------------------|--|-----------------------------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT J. (Jacob) ANSTINE</b>  |  |                      |  |                                   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC   |  | 2b. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC |  | 2c. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH <b>1/19/1930</b> |  | 6. AGE (IN YEARS) <b>51</b> YRS.   |  | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> SEC. <input type="checkbox"/>                                |  | 7c. DATE PRONOUNCED DEAD <b>3 28 19 81</b>  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>East Ave. &amp; Jefferson St.</b> |                                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dispatcher</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Toxicabs</b>  |   |  |
| 13a. STATE <b>Maryland</b>  |  |                      | 13b. COUNTY <b>-----</b>   |                                   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME <b>Ralph</b>  |  |                      | 15. MOTHER'S MAIDEN NAME <b>Pauline McIntyre</b>   |                                   |  | 16a. SOCIAL SECURITY NO. <b>212/26.6927</b>  |  |   | 17. INFORMANT ADDRESS <b>Floda E. Anstine--Same as 13e</b>                                   |   |  |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      | 16c. (IF YES, GIVE WAR OR DATES) <b>Korean War</b>   |                                   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture-dislocation of upper cervical spine</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>8/20</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b> |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |                                   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |  |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>PMX 3-28-1981</b>  |                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/auto collision.</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>  |                                   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>East Ave. &amp; Jefferson St., Balto. City, Md.</b>  |  |   |  |   |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |                                   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>  |  |                      | TITLE (SPECIFY) <b>Assistant</b>   |                                   |  |  |  |   | DATE SIGNED <b>3-28-81</b>   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                      | ADDRESS <b>111 Penn St.</b>  |                                   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |                      | 23b. DATE <b>3/ 30/1981</b>  |                                   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                            |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley Inc., Dundalk Md 21222</b>   |  |                      |  |                                   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1981</b>   |  |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 6 6 9 0  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>PAULINE ANTHONY</i>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>3-16-81</i>  |  | 2b. HOUR <i>4:40 A.M.</i>   |  |
| 3 SEX <i>Female</i>  |  | 4 RACE <i>Negro</i>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <i>7 20 27</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>53</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.   |  |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secour Hosp.</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>MD</i>   |  | 13b. COUNTY <i>Baltimore</i>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS <i>2015 Rayner Ave.</i>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Marie Harding</i>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie Holmes</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  | 16b. SOCIAL SECURITY NO. <i>093-36-7446</i>  |  | 17 INFORMANT ADDRESS <i>Deborah Johnson 2015 Rayner Ave.</i>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arrhythmia manifested by Bradycardia</i><br>5939<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Hypertensive arteriosclerotic heart disease</i><br>(c) <i>End stage Renal disease</i> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><i>Diabetes mellitus with retinopathy nephropathy</i>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/00</i> 19 <i>81</i> to <i>3/16</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/16</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did (I) did not see the body after death.                         |  |  |  |  |  |   |  |
| 22b. SIGNATURE <i>Juan A. Beltran</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED <i>3/16/81</i>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JUAN A. BELTRAN</i>   |  |  |  | 22e. ADDRESS <i>Bon Secours Hospital</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>3/21/81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Frederick Mem. Pk.</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Long Island N.Y.</i>   |  |
| 24 FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i> ADDRESS <i>1101 E. North Ave.</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>MAR 17 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 6 9 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWARD H. APPEL  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 25 81 |  |  | 2b. HOUR<br>1150A   |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 28 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Contracting   |  |  |  |  |  |   |  |  |
| 13a. STATE<br>Md.   |  |  | 13b. COUNTY                                    |  | 13c. CITY OR TOWN<br>Balto.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>5926 Glen Falls Ave. -21206  |  |  |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Appel   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Mueller  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 218-09-1137  |  | 17. INFORMANT<br>ADDRESS<br>Margaret K. Appel - 5926 Glen Falls Ave. 21206   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) OAT CELL CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 min<br>1 year |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13 19 81, to 3/25 19 81, that (I) (we) last saw the deceased alive on 3/24 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br>Paul Gertler  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                 |  | 22c. DATE SIGNED<br>3/25/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. PAUL GERTLER   |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-27-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge, Md.                 |  |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.-21206  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1981   |  |   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 5 9 2  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR <b>Dorothy Argus</b>   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY ARGUS</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>9</b> YEAR <b>81</b>   |  | 2b. HOUR <b>5:35A</b> M  |  |
| SEX <b>Female</b>   |  | 4. RACE <b>Ex White</b>  |  | 5. DATE OF BIRTH MONTH <b>05</b> DAY <b>05</b> YEAR <b>12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Ohio</b> 13b. COUNTY <b>Franklin</b> 13c. CITY OR TOWN <b>Columbus</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1399 Cambridge</b>  |  |  |  |
| 14. FATHER'S NAME FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>Wall</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Byrd</b> MIDDLE <b>-</b> LAST <b>Birk</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES)   |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>276-56-0912</b>   |  | 17. INFORMANT ADDRESS <b>Ohio 43202</b><br><b>Miss Pamela Argus 2636 Dayton Ave. Columbus,</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF BREAST.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 yrs.</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (he/she) attended the deceased from <b>3/9/81</b> to <b>3/9/81</b> , that (he/she) lost saw the deceased alive on <b>3/9/81</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>A. K. Chopra</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED <b>3/9/81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. K. CHOPRA</b>   |  |  |  | 22e. ADDRESS <b>ST. AGNES HOSPITAL BALTIMORE MD. 21229</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>Mar. 11, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md/</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b> ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

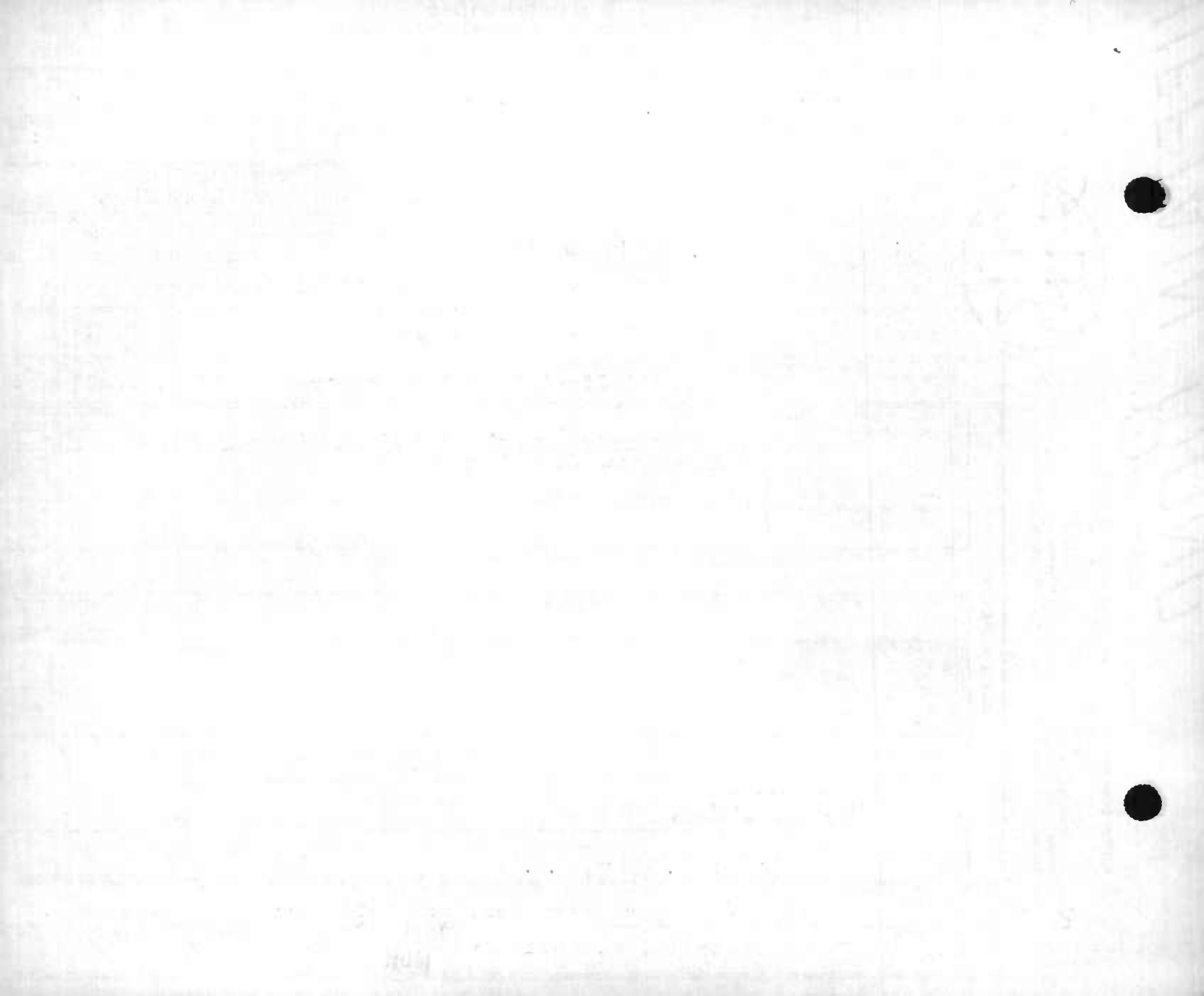


3/21/81  
Chapman M.

100-1-1000  
100-1-1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |   |  |  |  | REG. NO. 06693   |  |
|--|--|----------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Willie B. Armstrong</b>  |  |                      |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>3 7 1981</b> |  |
| 1. SEX <b>Female</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>21</b> YEAR <b>19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.                                |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD MONTH <b>3</b> DAY <b>7</b> YEAR <b>1981</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>201 N. Washington Street</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 14. STREET ADDRESS <b>201 N. Washington Street</b>   |  |
| 14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Gilmore</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Lydia</b> MIDDLE <b>Smith</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>212-32-0150</b>   |  | 17. INFORMANT ADDRESS <b>Lillie Armstrong 2015 N. Smallwood</b>               |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br><b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                      |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |   |  | DATE SIGNED <b>3/7/81</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |                      |  | 23b. DATE <b>3/12/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>                  |  | 23d. LOCATION CITY OR TOWN <b>Catonsville</b> COUNTY <b>Frederick</b> STATE <b>MD.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>WM. C. MARCH F/H INC.</b> ADDRESS <b>1101 E. North Ave</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1981</b>                               |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS OCCUR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |                                |   |  |   |  | REG. NO. 06694                               |  |
|--|-------------------------|---|--|---|--------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Inez Ashburn</b>  |                         |   |  |   |                                | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3 31 19 81</b> |  | 2b. HOUR <b>10:05</b>   |  |  |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 6 14 66 87</b> YRS.  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>15</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED<br>DEAD <b>3 31 19 81</b>   |  | 2d. HOUR <b>10:05</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>2719 Parkwood Ave.</b>                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unkn</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lizzie Brown</b>  |                                |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>214-12-4344</b>  |                                | 17. INFORMANT<br><b>Hazel Wright</b>  |  | ADDRESS<br><b>Conway, S.C.<br/>1711 Highland Ave.</b>                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |                         |   |  |   |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |   |  |   |                                |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                                |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Hormez R. Guard</i>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |                                | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>4/1/81</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |  |   |                                |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>4/4/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |                         | ADDRESS<br><b>1101 E. North Ave</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 03 1981</b>   |                                | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |



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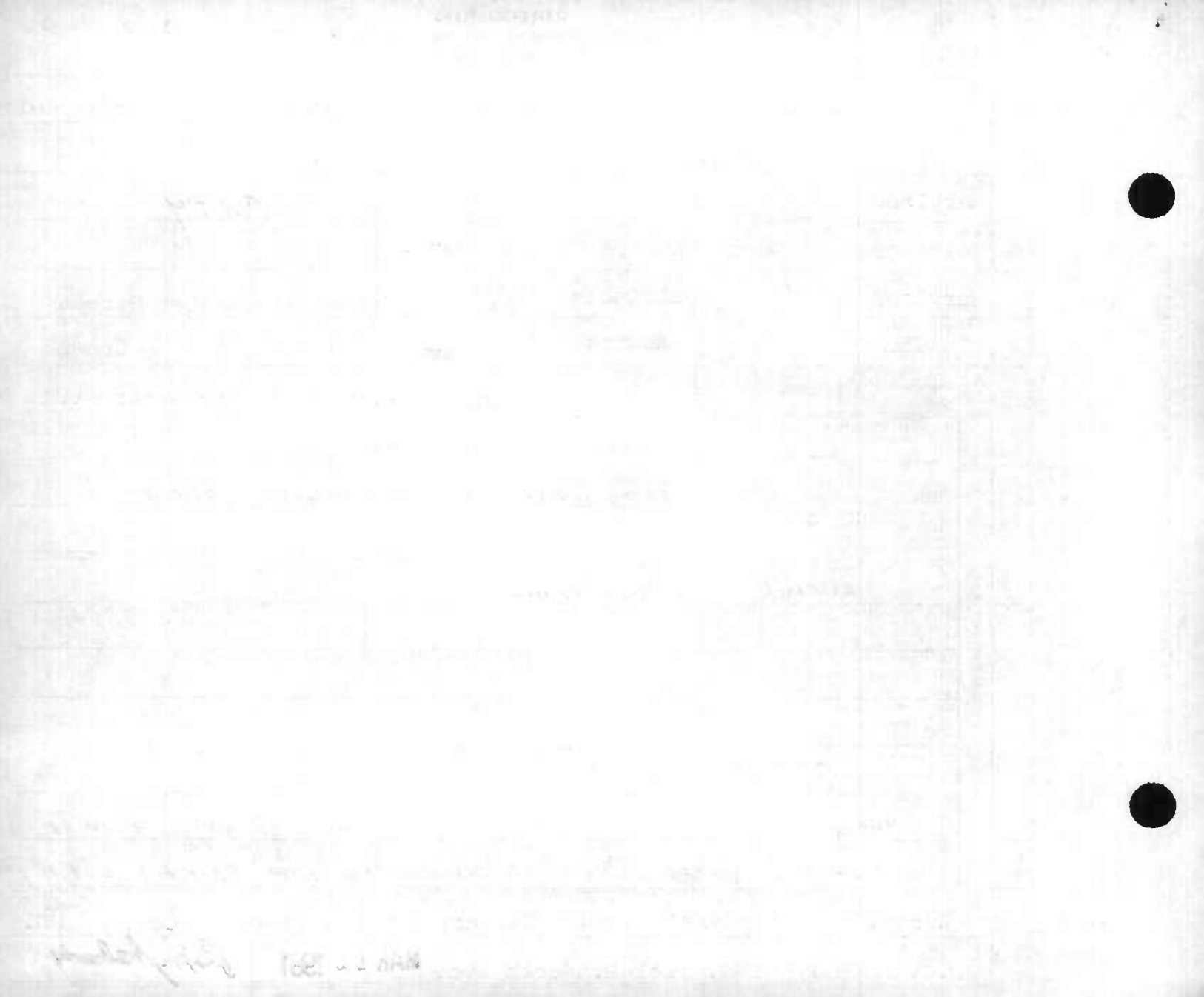
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8106695  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR  |  |   |  |
| KATIE ASKINS  |  |  |  | MARCH 10 1981 10:03 AM  |  |   |  |
| 3. SEX F  |  | 4. RACE BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS   |  |
| 2   |  | 2  |  | 95  |  | 86  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland  |  | USA  |  |   |  | City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF WITHIN SUBURBAN CITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   |  | North Charles General Hosp.  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Baltimore  |  | 13c. STREET ADDRESS   |  |   |  |
|   |  |  |  | 2744 Winchester Street  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |   |  |
| Tom Askins  |  | Mary Brown   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |   |  |
|   |  |  |  | Mary Franklin 2744 Winchester St.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ANEMIA HYPONATREMIA   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 2, 19 81, to MARCH 10, 19 81, that (I) (we) lost saw the deceased alive on MARCH 10, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c. DATE SIGNED  |  |
| C. VERGARA - SCAPES   |  | MD   |  |   |  | 3-10-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |
| C. VERGARA - SCAPES   |  | N. CHARLES GEN. HOSP. BALT. MD. 21218  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 3/14/81  |  | 23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD.   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| WM. C. MARCH F/H INC. 1101 E. North Ave.  |  |  |  | MAR 12 1981   |  | [Signature]   |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-3380.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH   |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                            |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                            |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |   |  |
| JAMES  |  | 3 30 81   |  | MALE   |  | BLACK  |  | 1 21 10  |  | 71 YRS.  |  | USA  |  |   |  | BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS  |  |   |  |
| BALTIMORE  |  | UNIVERSITY  |  | RETIRED  |  |  |  | MD   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1609 RETREAT ST.   |  |   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                 |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | 17. ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC HEPATOMA</u><br><u>1550</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |
| ALBERT   |  | ELLA  |  | NO   |  | 218-01-5766  |  | Mrs. Dorothy Atkins  |  | 1609 Retreat St.   |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |
|  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 22a. certify that (1) (this hospital) attended the deceased from <u>2/24</u> , 19 <u>81</u> , to <u>3/30</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)               |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                             |  |   |  |
| John H. Nagel MD   |  |   |  | 3/30/81  |  | JOHN H. NEZBER MD  |  | 22 - S. GREENE ST - 21201  |  | Burial   |  | 4/2/81   |  | Church Cemetery   |  | Cambridge Md   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 25c. DATE REC'D. BY REGISTRAR  |  | 25d. REGISTRAR'S SIGNATURE                                 |  | 25e. DATE REC'D. BY REGISTRAR  |  | 25f. REGISTRAR'S SIGNATURE  |  | 25g. DATE REC'D. BY REGISTRAR  |  |   |  |
| William C. March   |  | F/H 1101 E. North Ave   |  | MAR 31 1981  |  | [Signature]  |  | MAR 31 1981  |  | [Signature]  |  | MAR 31 1981  |  | [Signature]   |  | MAR 31 1981  |  |   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EDWARD J. AUGUSTYNIAK</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-18-81</b>   |  | 2b. HOUR<br><b>12:40AM</b>   |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4-9-17</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b>                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>FRANK AUGUSTYNIAK</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY KALACZYNSKI</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>YES WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 10 0981</b>   |  | 17 INFORMANT ADDRESS<br><b>GENEVIEVE AUGUSTYNIAK SAME</b>                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>2396</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>BRAIN EDEMA</b><br>(c) <b>BRAIN TUMOR</b>                       |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>COMA STATUS-POST, CRANIOTOMY</b>   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>FEB. 81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CRANIOTOMY, BRAIN TUMOR</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>2-23</b> 19 <b>81</b> , to <b>3-18</b> 19 <b>81</b> , that (I) we lost saw the deceased alive on <b>3-18</b> 19 <b>81</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>V. Balakrishnan</b>  |  | DEGREE<br><b>MD.</b>   |  | 22c. DATE SIGNED<br><b>3-18-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. V. BALAKRISHNAN, MD.</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MD. 21231</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE IF)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/21/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS CEM</b>                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RAYMOND H. KACZOROWSKI 2525 FLEET ST.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. [Signature]</b>                           |  |

11 0 4

RECEIVED  
NOTES



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| DECEASED NAME (TYPE OR PRINT) <b>FREDA</b>  |  | MONTH <b>MARCH</b> DAY <b>25</b> YEAR <b>1981</b>   |  | 9:35 AM  |  |
| 3. SEX <b>FEMALE</b>  | 4. RACE <b>CAUCASIAN</b>   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
|   |  | MONTH <b>MAY</b> DAY <b>27</b> YEAR <b>1906</b>   |  | 74 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINVALE HEBREW GERIATRIC CENTER + HOSPITAL</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>  |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  | 13c. STREET ADDRESS <b>APT. 2A 6807 PARK HTS. AVE. 21215</b>                   |  |
| 14. FATHER'S NAME <b>JOSEPH</b>   |  | 15. MOTHER'S MAIDEN NAME <b>ADELE</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>    |  |
| 17. INFORMANT <b>DR. JOSEPH H. AXELROD</b>  |  | 18. SOCIAL SECURITY NO. <b>216-32-8916</b>  |  | 19. ADDRESS <b>3511 PHILIPS DR. BALTO., MD 21208</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>CVA</b>  |  |   |  |  |  |
| 4360  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| (b)   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |
| (c)   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/17</b> , 19 <b>81</b> , to <b>3/25</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>3/25</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE <b>Estrelita O. Ku</b>   |  | DEGREE  |  | 22c. DATE SIGNED <b>3/25/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KU</b>  |  | 22e. ADDRESS <b>LEVINVALE HEBREW GERIATRIC CENTER + HOSPITAL</b>  |  | 22f. DATE REC'D. BY REGISTRAR <b>APR 02 1981</b>                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>3/26/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH YEHUDA ANSHE KURLAND</b>            |  |
| 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>   |  | 23e. COUNTY <b>MARYLAND</b>   |  | 23f. STATE <b>MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  | 24a. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  | 24b. DATE REC'D. BY REGISTRAR <b>APR 02 1981</b>                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

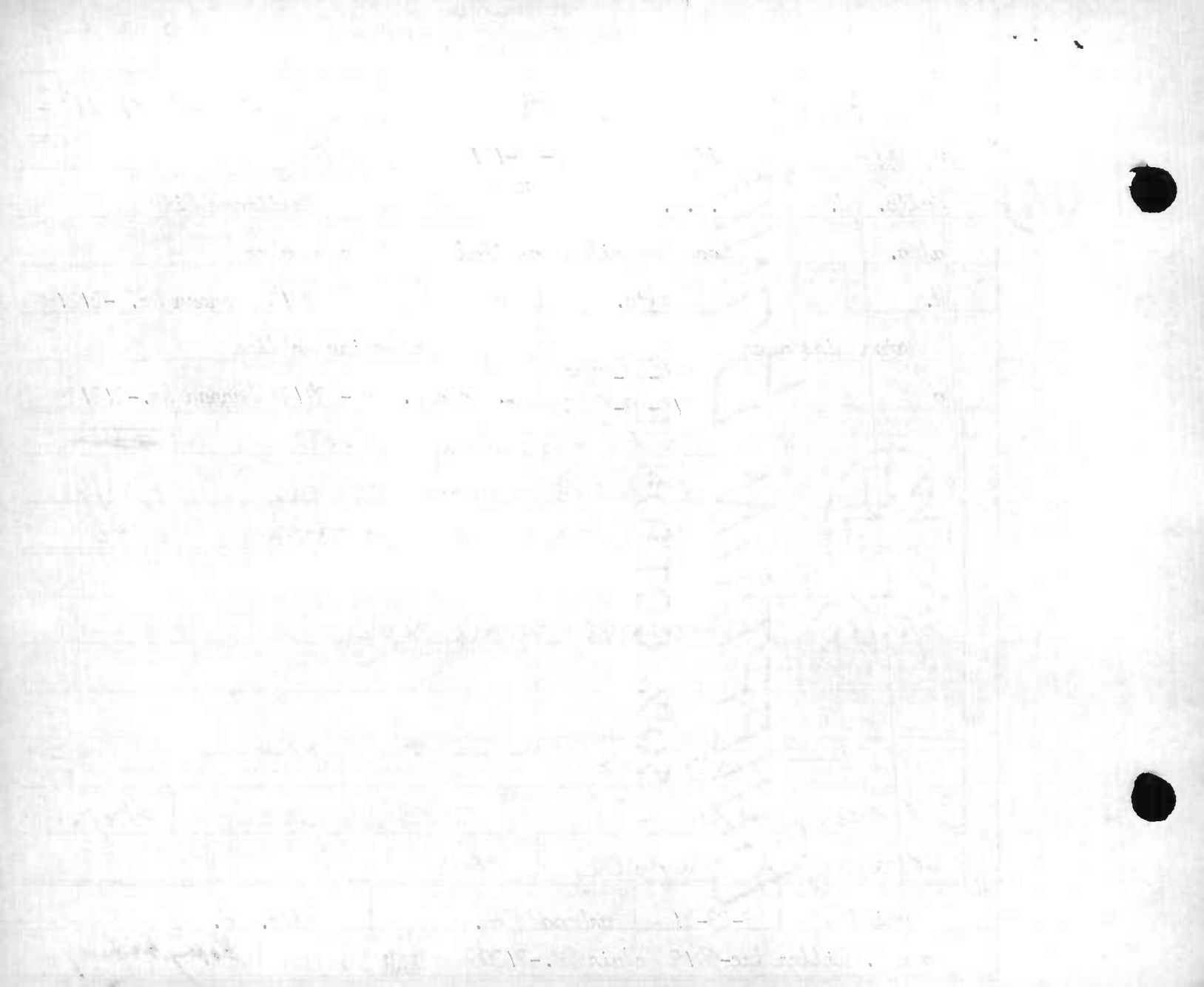


STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 0 9 9

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Helen NMW AV</i>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3 20 81</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><i>7-24-1913</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>67</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Good Samaritan Hospital</i> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Home Maker</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Balto.</i>   |  |
| 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br><i>3413 Shannon Dr. -21213</i>  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Anton Hirshauer</i>  |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Katherine Berling</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  |
| 16b. SOCIAL SECURITY NO.<br><i>220-46-5205</i>   |  | 17. INFORMANT ADDRESS<br><i>Mr. John A. Ay - 3413 Shannon Dr. -21213</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>PERFORATED SMALL BOWEL</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>PANCREATIC CA &amp; METASTASIS</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3/19/81</i><br><i>11/80</i> |  | PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)       |  |
| 19a. DATE OF OPERATION<br><i>3/19/81</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>PERFORATED SMALL BOWEL</i>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                   |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/10</i> , 19 <i>81</i> , to <i>3/20</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/20</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><i>Rogelio A. Filamor</i>  |  | 22c. DATE SIGNED<br><i>3/20/81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ROGELIO A. FILAMOR</i>   |  | 22e. ADDRESS<br><i>CRIT</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-23-81</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood Cem.</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>   |  |
| 24. FUNERAL DIRECTOR (NAME)<br><i>John C. Miller Inc-6415 Belair Rd.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 23 1981</i>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Rafael Hebrido</i>  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO.  |  |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elwin Leroy Avers</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 24, 1981</b>                      |  | 2b. HOUR<br><b>12:25 PM</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 16, 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Michigan</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U.S. Public Health Service Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seaman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shipping</b>  |  |
| 13a. STATE<br><b>Michigan</b>  |   | 13b. COUNTY<br><b>Allegan</b>   | 13c. CITY OR TOWN<br><b>Martin</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Denton Avers</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Etta Green</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>USN 1934-38 370 12 1127</b>   |   | 17. INFORMANT<br><b>Phyllis Depue (daughter) 3425 Thornhill</b><br><b>U.S.P.H.S. medical records Kalamazoo, Mich</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4423</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>SURGERY &amp; ANESTHESIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>ANEURYSM RIGHT FEMORAL ARTERY</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>3 hours</b><br><b>6 mos</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>exploration of r. femoral artery/ and bypass graft</b>  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>3/24/81</b>   |   | 19b. CONDITION FOR WHICH OPERATED<br><b>exploration of r. femoral artery/ and bypass graft</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                    |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Dennis R. Ward, M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3/25/81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dennis R. Ward, M.D.</b>   |   | 22e. ADDRESS<br><b>U.S.P.H.S. Hospital, 3100 Wyman Pr. Dr.</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |   | 23b. DATE<br><b>3-28-1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Graceland Mem. Park Grand Rapids Kent, Mich.</b>                            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. Barnes</b>   |   | ADDRESS<br><b>Fleming Funeral Service-Benson, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>  |   |  |

BP \_\_\_\_\_

March 21, 1951 10:25 AM

February 16, 1951

U.S. ...

U.S. Public Health Service Hospital, Baltimore

March 11, 1951

March 11, 1951

U.S. P.H.S. Medical Records

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

March 11, 1951

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |  |  |                 |  |
|--|--|---|--|---|---|--|--|--|-----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BERNARD L. AYMOLD, JR.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 4, 1981                   |   |   | 2b. HOUR<br>a<br>2:36<br>m   |  |  |                 |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 25, 1920   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Agnes Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-employed               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CPA                     |  |                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>4601 Franklinton Road                 |  |                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernard L. Aymold, Sr.   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dale Tall             |   |   |  |  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II       |   | 17. INFORMANT<br>Mrs. Dorothy Aymold  |  |  |  | ADDRESS<br>Same |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>4100 IMMEDIATE CAUSE (a) acute coronary thromboses<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |                 |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 28 1965, to March 4 81, that (I) (we) lost saw the deceased alive on 11-18-80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |  |   |   |  |  |  |                 |  |
| 22b. SIGNATURE<br>Dr. Harry S. Gimbel, M.D.  |  |   | DEGREE<br>M.D.   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-5-81   |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Harry S. Gimbel, M.D.   |  |   | 22e. ADDRESS<br>5226 Balto. National Pike, Balto., Md.                 |   |   |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/6/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Md. |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.  |  |   | ADDRESS<br>4905 York Road Balto., Md. 21212                            |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafael R. Brady  |                 |  |

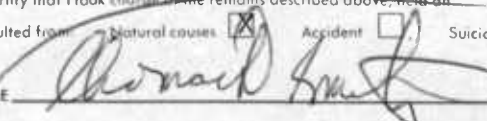
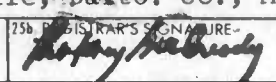
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |   |   |  |   |  | REG. NO.   |  |
|---|-------------------------|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Horace Crookham Ayres</b>  |                         |   |  |   |   |   |  |   |  | 2a. DATE OF DEATH<br>KNOWN ESTIMATED <input checked="" type="checkbox"/> 3 MONTH DAY YEAR 26 19 81 |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Mar. 8, 1931</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 50 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 3 26 19 81 | 7d. HOUR<br>P. M. 1:28 P. M.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Reporter</b>                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sunpapers</b>                               |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>222 St. Paul St.</b>                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Horace Crookham Ayres</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara May Turner</b>  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Korean</b>  |  | 16c. SOCIAL SECURITY NO.<br><b>536-28-7552</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Clara M. Ayres Lacey, Washington</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |                         |   |  |   |   |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |                         |   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY:<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br>M.D. <b>Deputy Chief</b>   |  |   |   | MEDICAL EXAMINER  |  | DATE SIGNED <b>3/27/81</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |                         | ADDRESS <b>111 Penn Street, Baltimore, Md. 21201</b>  |  |   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |                         | 23b. DATE<br><b>Mar. 30, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto. Co., Md.</b>                                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>6500 York Rd.</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |
| Mitchell-Wiedefeld Home, Inc. Balto., Md.   |                         |   |  |   |   |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                            |  |
|--|--|---|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nicholas M. Baccala Sr.</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 10, 1981</b>              |   | 2b. HOUR<br><b>3:30A M</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10-9-23</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57 yrs.</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto..</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13d. STREET ADDRESS<br><b>3652 Chesterfield Ave. Baltimore, Md. 21213</b>  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael A. Baccala</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maria Della Viola</b> |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF KNOWN, GIVE YEAR OR DATES) <b>WWII 217-18-9732</b>  |  | 17. INFORMANT ADDRESS<br><b>Stella G. Baccala 3652 Chesterfield Ave. #13</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>March 9 19 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                            |  |
| 22a. I certify that <b>30</b> (this hospital) attended the deceased from <b>March 9</b> , 19 <b>81</b> , to <b>March 10</b> , 19 <b>81</b> , that <b>X</b> (we) lost <b>saw the deceased alive on above, X (we) (did) not view the body after death.</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated  |  |   |  |   |                            |  |
| 22b. SIGNATURE<br><b>Michael Hull</b>  |  |   |  | 22c. DATE SIGNED<br><b>3/10/81</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Hull, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-13-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>  |                            |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |  | 24. FUNERAL HOME NAME<br><b>Schimmunek Funeral Home 3331 Brehms Lane #13</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>   |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |                            |  |



Metastatic Carcinoma



c/o Maryland General Hospital

Michael Hill, M.D.

MAR 11 1981

*Handwritten signature*

## CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>SAMUEL JOHN NIEDZWIECKI Baer</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-24-81</b> |  |  | 2b HOUR<br><b>8<sup>00</sup> A.M.</b>  |  |  |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-20-96</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASH. D.C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY BALTO.</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSP.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GENERAL MOTORS</b>               |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD.</b>   |  | 13b COUNTY<br><b>---</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>511 S. MACON ST. BALTO., MD.</b>                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL NIEDZWIECKI</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN ?</b>   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  |  | 16b SOCIAL SECURITY NO.<br><b>W.W.I. 216-05-1941</b>   |  | 17 INFORMANT<br><b>ALICE A. BAER</b>   |  | ADDRESS<br><b>511 S. MACON ST. BALTO., MD.</b>   |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gastro-intestinal bleeding c.u.</b><br>5789<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days &amp; remained</b> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a:<br><b>stroke - L hemiplegia June 79</b>   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>9-9-79</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>stroke - L hemiplegia</b>  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Nov 19 79</b> to <b>24 Mar 1981</b> , that (I) (we) last saw the deceased alive on <b>23 Mar 81</b> 19 <b>---</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><b>Edmund B. Beacham M.D.</b>   |  |  |  | DEGREE<br><b>---</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>24 Mar 81</b>                                      |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. G. BEACHAM M.D.</b>  |  |  |  | 22e ADDRESS<br><b>4940 EASTERN AVE. BALTO., MD.</b>  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>3-27-81</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS CEM</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>6515 BOSTON AVE. BALTO., MD.</b>   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Deiler &amp; Son, Inc.</b>  |  |  |  | ADDRESS<br><b>901 S. CONKLING ST. BALTO., MD.</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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10-11-1940

10-11-1940

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10-11-1940

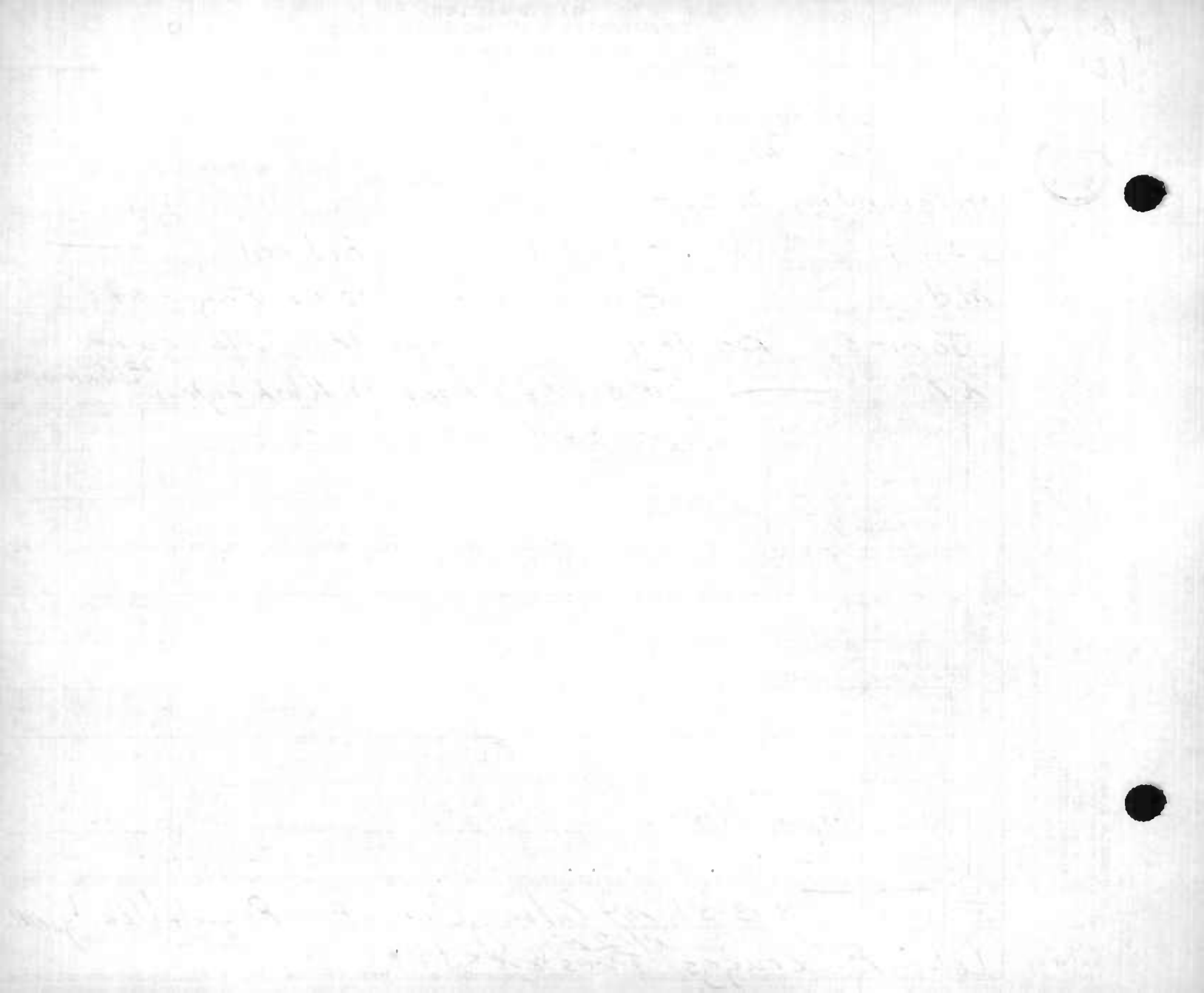
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

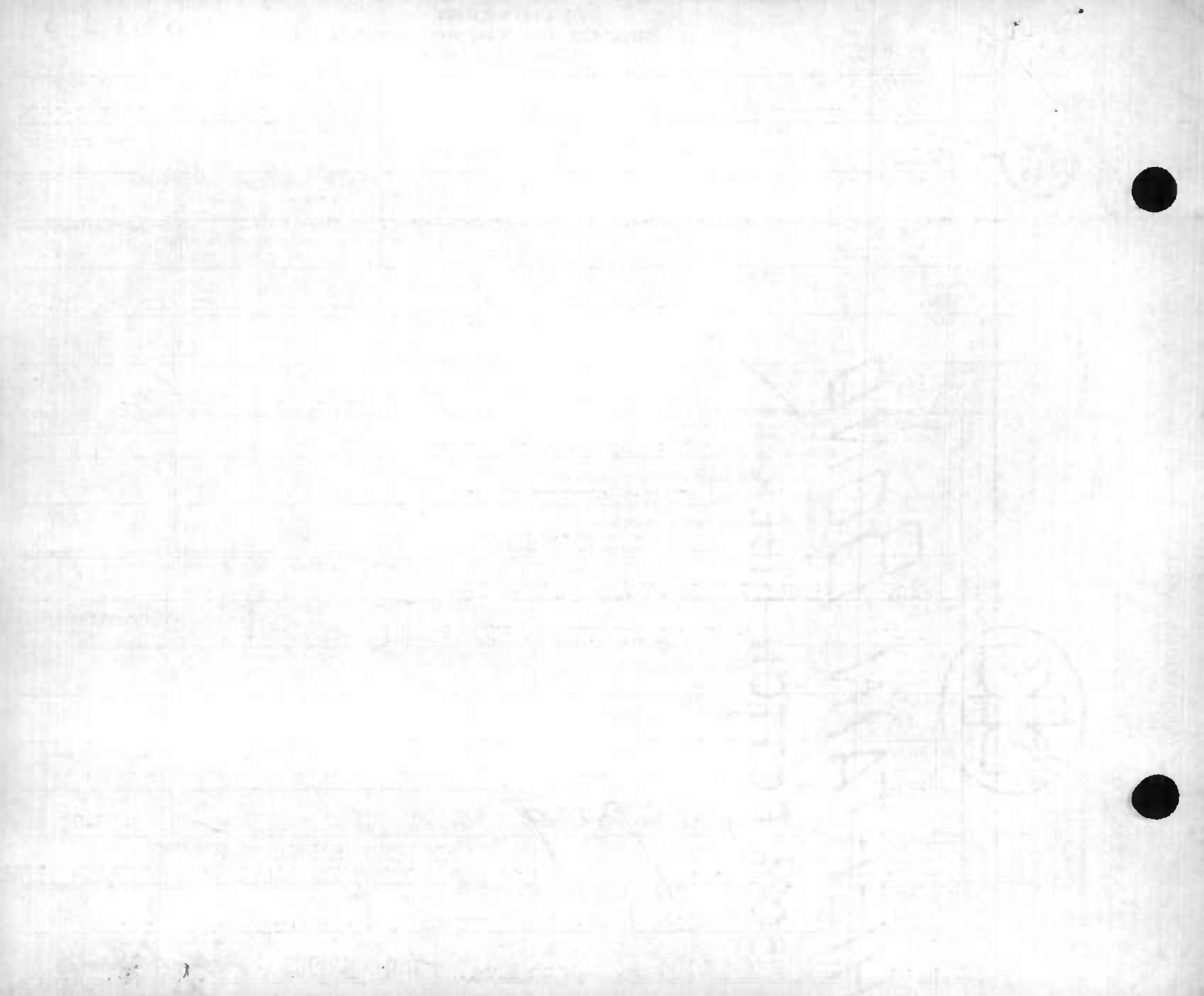
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-1234.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | MONTHS DAYS HOURS MIN.  |  |
| FIRST MIDDLE LAST   |  | MARCH 23, 1981   |  | 9:10 PM   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| Male  |  | Negro  |  | MONTH DAY YEAR  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| S.C.  |  | USA  |  | 72 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore   |  | Church Home & Hospital   |  | Baltimore City MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| MD  |  |  |  | Baltimore   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13d. INSIDE CITY LIMITS?  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| -   |  | Alice Williams   |  | 13e. STREET ADDRESS   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |
| No  |  | 219-07-3600  |  | Ruth Baker 1925 N. Castle St.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIAC PULMONARY ARREST  |  |  |  |   |  |
| 5939 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (b) URETHRAL STRICTURE WITH CALCULI   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| (c) RENAL INSUFFICIENCY   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |
| ACUTE RENAL INSUFFICIENCY AND DEHYDRATION   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
| 3-9-81  |  | URETHRAL STRICTURE WITH CALCULI  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-15, 1981, to 3-23, 1981, that (I) (we) last saw the deceased alive on 3-23, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  | 22c. DATE SIGNED  |  |
| Sompalli Prasad   |  |  |  | 3-23-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |
| SOMPALLI PRASAD, M.D.   |  |  |  | CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY, BALTIMORE, MARYLAND 21231  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 3/30/81  |  | Mt. Calvary Cem.  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR   |  |
| Wm. C. March F/H  |  | Baltimore Co. MD   |  | MAR 26 1981   |  |
| 1101 E. North Ave.  |  | ADDRESS  |  | 23f. REGISTRAR'S SIGNATURE  |  |
|   |  |  |  | Ruth Baker  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |  |
|---|--|---|---|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR (Last) <b>BAKER, Geo. E</b>  |  |   |   |   | 8 1 0 6 / 0 7<br>REG. NO.  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE E BAKER</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>21</b> YEAR <b>81</b>  |  |   | 2b. HOUR <b>4:45</b> PM   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |   | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>28</b> YEAR <b>1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sgt of Guards</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Kennecott Ref.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |  |   |   |  |
| 13a. STATE <b>Md</b>  |  | 13b. COUNTY <b>-</b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>3118 Elbert Street</b>   |  |
| 14. FATHER'S NAME FIRST <b>E. Eugene</b> MIDDLE <b>Baker</b> LAST   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Marion</b> MIDDLE <b>Ebert</b> LAST  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |   |   | 16b. SOCIAL SECURITY NO. <b>217 05 5908</b>  |  | 17. INFORMANT ADDRESS <b>Mary F. Baker Same</b>                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anterior septal MI acute</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>C</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>91p Below Knee amputation of Rt leg.</b> |  |   |   |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-21-81</b> , 19 <b>81</b> , to <b>3-21</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3-21</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |   |  |
| 22b. SIGNATURE <b>Mathew</b> DEGREE   |  |   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED <b>3-21-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. Mathew (A. Mathew)</b>  |  |   |   |   | 22e. ADDRESS   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   | 23b. DATE <b>3/24/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Balto. Md</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Burgess F.H</b> ADDRESS <b>3631 FALL RD</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE <b>Esther H. B...</b>                    |   |  |

MAR 26 1981

BALTIMORE CITY

OFFICE OF THE

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1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 427-3735.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8-1 06708  |   |
|--|--|---|--|--|---|
| FOR<br>1- STATE REGISTRAR  |  |   |  | REG. NO.   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HENRY SCOTT BAKER</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 5, 1981</b>                               |  | 2b. HOUR p<br><b>12:30 M</b>  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 5, 1895</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>85</b>  |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>                                |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Financial VP</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>JHU</b>  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Balto.</b>   | 13c CITY OR TOWN<br><b>Baltimore</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dr. Robert W. Baker</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Abby Scott</b>                     |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW I</b>   |  | 16b SOCIAL SECURITY NO.<br><b>220 30 2892</b>   |  | 17 INFORMANT ADDRESS<br><b>Henry S. Baker, Jr. Balto., Md.</b>                                 |   |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AORTIC STENOSIS</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years +</b><br><b>10 years +</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |  |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a I certify that (I) (the hospital) attended the deceased from <b>January 19 79</b> to <b>March 5 19 81</b> that (I) (we) lost<br>saw the deceased alive on <b>Jan 24 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Charles E. Ellicott MD</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br><b>Mar 5, 1981</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Charles E. Ellicott, M.D.</b>  |  |   | 22e ADDRESS<br><b>1134 York Road, Balto., Md.</b>                                      |  |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b DATE<br><b>3/7/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  |   |  |  |   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rafael A. Brady</b>   |   |

BP \_\_\_\_\_

14000 York Road, Balto., Md. 21212  
 Henry W. Jenkins & Sons Co.  
 217/81 T. Green Mount  
 Balto., Md.

Dr. Charles E. Elliott, M.D., 1154 York Road, Balto., Md.

Yes WW I 820 90 2500 Henry S. Baker, Jr., Balto., Md.  
 Dr. Robert W. Baker Apply Scott  
 Maryland Baltimore x 6003 Hunt Ridge Road  
 Balto. Mercy Hospital Financial VP JHU  
 Wash., D.C. U Baltimore City  
 Also this 1912  
 HENRY C. BAKER, Jr., 1912



UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 6 7 1 0  
CERTIFICATE OF DEATH

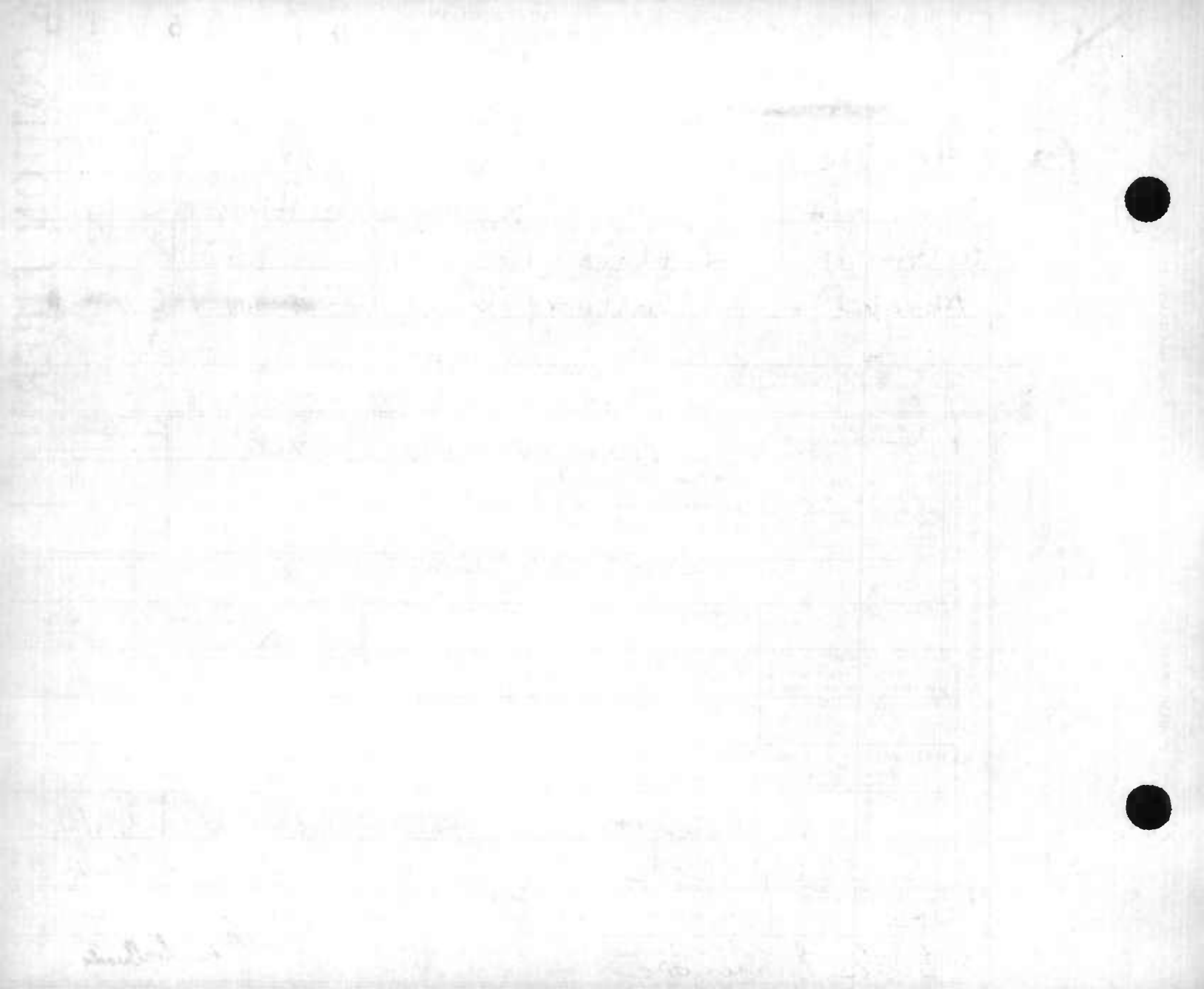
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

|  |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>KATHLEEN</b>   |  | FIRST<br><b>ST. JOHN</b>  |  | MIDDLE<br><b>Baker</b>  |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH<br><b>3</b> YEAR<br><b>18-1981</b> 2b. HOUR<br><b>1045</b> M                                    |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH<br><b>11</b> DAY<br><b>09</b> YEAR<br><b>05</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS<br><b>75</b> DAYS<br><b>05</b> HOURS<br><b>45</b> MIN  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>929 S. Ellwood Ave. 21224</b>                              |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Thomas</b> MIDDLE<br><b>St. John</b> LAST<br><b>St. John</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Lillie</b> MIDDLE<br><b>Hensley</b> LAST<br><b>Hensley</b>                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215.12.2912</b>  |  | 17. INFORMANT<br><b>Helen S. Stortz--Same as 13e</b>  |  |   |  | ADDRESS  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-----</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>S. Swanagool</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3/18/81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. SWANAGOO</b>  |  |   |  | 22e. ADDRESS<br><b>Lutheran Hospital, Baltimore, MD</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/19/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b> COUNTY<br><b>Maryland</b> STATE    |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley Inc. Dundalk, Md 21224</b>  |  |   |  |   |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 1 1

REG. NO.

|   |  |   |  |  |   |  |   |  |  |
|---|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Randolph Baker Sr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/21/81</b>                  |  |   | 2b. HOUR<br><b>4:30</b> M  |   |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Black</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 30 1909</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2603 Garrett Avenue</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Archie Baker</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lydia Kirkland</b> |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-10-9212</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>John Baker 2603 Garrett Avenue</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Cardiac disease.</b><br><b>4130</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Angina, Repeated</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Effects of Congestive Heart Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Several years</b> |  |   |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10 15 19 80</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/15 19 80</b> to <b>Mar 19 81</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>B.K. Yorkoff, MD</b>   |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/23/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.K. Yorkoff</b>  |  |   | 22e. ADDRESS<br><b>7401 Osler Dr. Towson, Md</b>                       |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/27/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md</b>                                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H</b>   |  |   | ADDRESS<br><b>1101 E. North Ave</b>                                    |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. Yorkoff</b>  |  |



10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must notify the coroner.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 6 / 1 2   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>Pilar</b>   |  |   |  | 2a DATE OF DEATH MONTH <b>3</b> DAY <b>7</b> YEAR <b>81</b>   |  |  |  |
| 3 SEX <b>Female</b>  |  |   |  | 2b HOUR <b>9:37 AM</b>  |  |  |  |
| 4 RACE <b>oriental</b>   |  | 5 DATE OF BIRTH MONTH <b>10</b> DAY <b>12</b> YEAR <b>34</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>46 years</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philippines</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>Philippines</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So Baltimore General Hospital</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electronics</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Electronic Co.</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD.</b>   |  |   |  | 13b COUNTY <b>ANNE ARUNDEL</b>  |  | 13c CITY OR TOWN <b>Glen Burnie</b>  |  |
| 14 FATHER'S NAME FIRST <b>Calalina</b> MIDDLE <b></b> LAST <b>Touera</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Betra</b> MIDDLE <b></b> LAST <b>Argone</b>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b SOCIAL SECURITY NO <b>220 68 4786</b>   |  | 17 INFORMANT ADDRESS <b>chart.</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Collapse.</b>  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Disseminated Intravascular Coagulation</b>   |  |   |  |   |  | 13 hrs.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatic Cirrhosis, thrombocytopenia with bleed thru p.</b>   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>obstructive jaundice cholelithiasis, Status post cholecystectomy</b>   |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION <b>3/6/81</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>obstructive jaundice</b>   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/20/81</b> , 19 <b>81</b> , to <b>3-7</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b SIGNATURE <b>[Signature]</b>   |  |   |  | DEGREE  |  | 22c DATE SIGNED <b>3/7/81</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A Pena M.D.</b>   |  |   |  | 22e ADDRESS <b>So Baltimore Gen. Hosp.</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b DATE <b>3/10/81</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemety.</b>   |  | 23d LOCATION CITY OR TOWN <b>Glen Burnie</b> COUNTY <b>A.A.</b> STATE <b>Maryland</b>                                  |  |
| 24 FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b> ADDRESS <b>Glen Burnie, Md.</b>  |  |   |  | 25a DATE REC'D. BY REGISTRAR <b>MAR 10 1981</b>   |  | 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

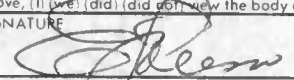



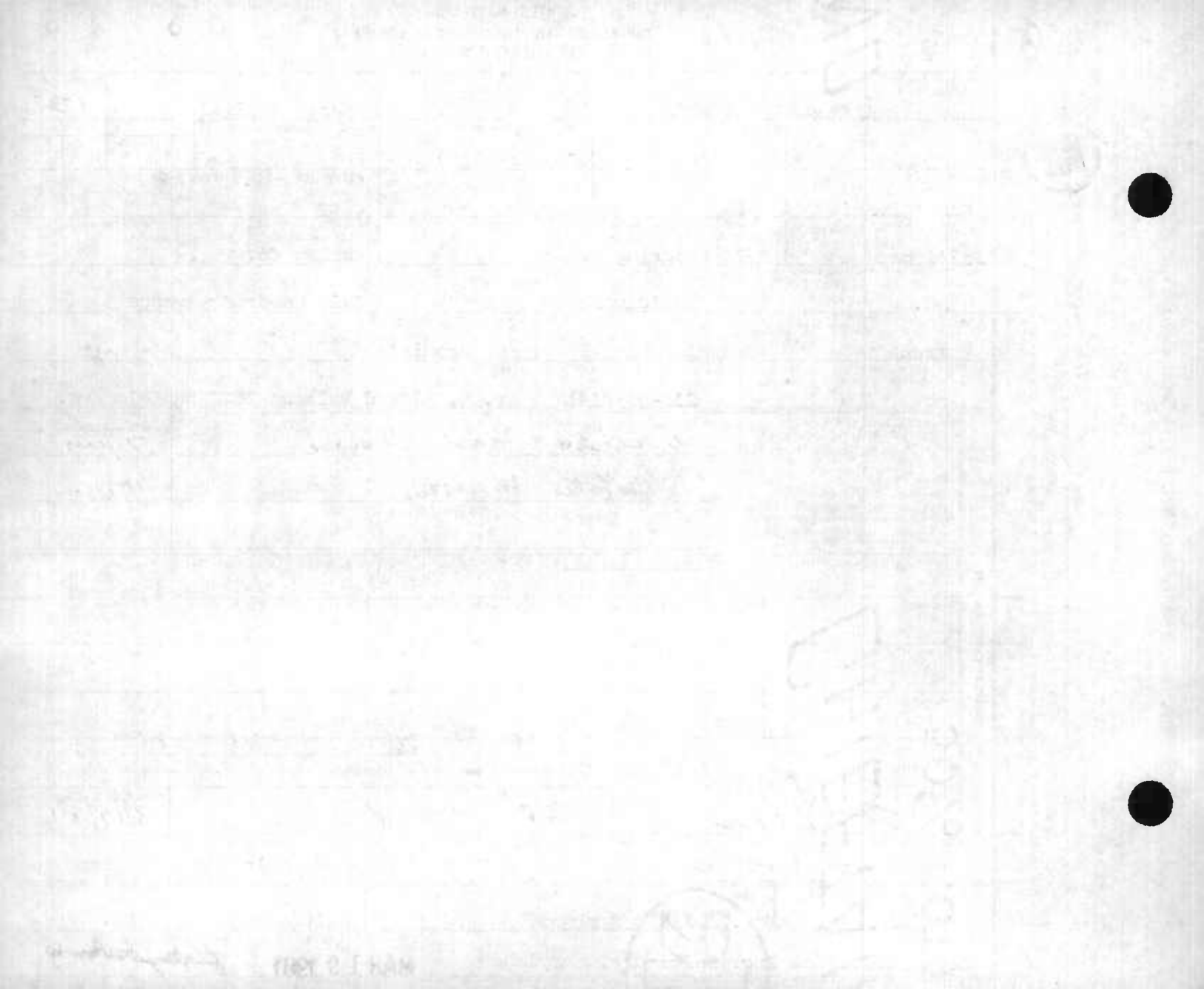
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 1 0 6 7 1 3   |  |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alfreda Ogenia Balasus</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 18, 1981</b>                          |   | 2b. HOUR<br><b>1450 P.M.</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 29, 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>city</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3410 Woodring Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Esskay Co.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3410 Woodring Avenue</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Prosniewski</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bronislaw -</b>                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-8141</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. M. Alfred Balasus 7622 Daniels Ave.</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Disease</b><br><b>2500</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 years</b><br><b>10 years</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> 19 <b>66</b> , to <b>3/18</b> 19 <b>81</b> , that (we) lost saw the deceased alive on <b>3/18</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/19/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward Alessi MD.</b>   |  | 22e. ADDRESS<br><b>6217 Harford Road Baltimore, Maryland</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 21, 1981</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br>        |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8106714  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Robert R. Baldwin</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 2 81</b>  |  |  |  | 2b. HOUR<br><b>1:45 p.m.</b>  |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 10 90</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90 YRS</b>   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Federal Guard</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>                              |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>WOODLAWN</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5419 CLIFTON AVENUE, 21207</b>                            |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRISON BALDWIN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SARAH STEWART</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW I 212-42-1417</b>  |  | 17. INFORMANT ADDRESS<br><b>EDWARD R. BALDWIN 205 DELIGHT ROAD, 21136 REISTERSTOWN, MD.</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute antero septal myocardial infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>severe anemia secondary to GI bleeding 24h Ca 9th the calcium</b> |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>3/2 1981</b> , that (I) (we) lost saw the deceased alive on <b>3/2 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Eugenio E. Benitez</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3/2/81</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Benitez</b>   |  |   |  | 22e. ADDRESS<br><b>3455 Wilkens Ave 21229</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>03-05-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY BALTIMORE MARYLAND</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |  | 24b. ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 24c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 25a. DATE RECEIVED BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)<br><b>MAR 4 1981</b>   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                                       |  |   |  |  |   |  |   | 8  | 1  | 0                            | 6 | 7 | 1 | 5 |
|--|--|---------------------------------------|--|---|--|--|---|--|---|--|--|------------------------------|---|---|---|---|
| FOR<br>1 - STATE REGISTRAR   |  |                                       |  |   |  |  |   |  |   | REG. NO.   |  |                              |   |   |   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JULIA M. BALL  |  |                                       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/10/81   |  |   |  |   | 2b. HOUR<br>6:30 a.m.  |  |                              |   |   |   |   |
| 3 SEX<br>fe  |  | 4 RACE<br>BLACK                       |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 15 06 |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS. |  |   | 7 UNDER 1 YEAR<br>MONTHS DAYS  |  | 7 UNDER 24 HRS<br>HOURS MIN. |   |   |   |   |
| 7a BIRTHPLACE<br>(COUNTRY)<br>VA   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |  |  |                              |   |   |   |   |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  |                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>710 Allendale St. |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home. |                              |   |   |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  |                                       |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>710 Allendale St.   |                              |   |   |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALLEN BALL  |  |                                       |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emily Ball   |  |   |  |   |  |  |                              |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-30 5344   |   | 17 INFORMANT ADDRESS<br>Ms. Lorraine Parker 710 Allendale St.  |  |   |  |   |  |  |                              |   |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA<br>4/49<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ISCHEMIC HEART DISEASE YEARS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                |  |                                       |  |   |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |                              |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                                       |  |   |  |  |   |  |   |  |  |                              |   |   |   |   |
| 19a. DATE OF OPERATION   |  |                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                              |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |                              |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |  |                              |   |   |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 80, to 3/10, 19 81, that (1) (we) last saw the deceased alive on 3/10, 19 81, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                       |  |   |  |  |   |  |   |  |  |                              |   |   |   |   |
| 22b. SIGNATURE<br>Ronald F. Sherer   |  |                                       |  |   | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>3/11/81                |                              |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RONALD F. SHERER  |  |                                       |  |   | 22e. ADDRESS<br>730 ASHBURTON ST. BALTO. MD. 21216   |  |   |  |   |  |  |                              |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                       | 23b. DATE<br>3-14-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbatus  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD.  |   |  |  |                              |   |   |   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Jas. A. Morton & Sons 1701 Laurens St.  |  |                                       |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McQuinn  |   |  |  |                              |   |   |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - ~~one to be filed - one to be filed - one to be filed~~ with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 / 1 6

|  |  |   |  |
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| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>William F Ballman   |  | MONTH DAY YEAR<br>March 10 1981   |  |
| 3. SEX<br>Male   |  | 2b. HOUR<br>2:20 PM   |  |
| 4. RACE<br>Caucasian   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 30 95  |  | 85 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>South Baltimore General Hospital   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Office Worker   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Penner Co.   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  | 13a. STREET ADDRESS<br>5308 Ballman Avenue  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 13b. CITY OR TOWN<br>Baltimore  |  |
| 11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>South Baltimore General Hospital  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 13a. STREET ADDRESS<br>5308 Ballman Avenue   |  | 13e. STREET ADDRESS<br>5308 Ballman Avenue  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christian F. Ballman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Biemiller   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>212-07-9229A  |  |
| 17. INFORMANT<br>ADDRESS<br>Mrs. Katherine M. Ballman  |  | 21.225  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHF<br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) ASCVD<br>(c) HBP                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>urinary retention, dementia  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. LOCATION<br>CITY OR TOWN COUNTY STATE   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) this hospital attended the deceased from 2/13 19 81 to 3/10 19 81, that (I) (we) last saw the deceased alive on 2/10 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br>Maureen L. Durkin MD   |  | 22c. DATE SIGNED<br>3/10/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAUREEN L. DURKIN   |  | 22e. ADDRESS<br>SBGH 3001 S. Hanover St, Balt MD  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/13/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Anne Arundel MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>237 E. Patapsco Avenue Baltimore, MD 21225   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |   |   |
|---|--|---|--|--|--|--|---|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.   |  |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BEULAH M. BANKS</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 21, 1981</b>   |  |   | 2b. HOUR <b>9<sup>40</sup> PM</b>                         |   |
| 3 SEX <b>FEMALE</b>   |  | 4 RACE <b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>MARCH 25, 1889</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.  |   | 7 UNDER 1 YEAR MONTHS DAYS<br>7 UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.                     |   |   |   |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>319 HOMELAND SOUTHWAY APT 2A.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STORE OWNER</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>CONFECTIONARY</b>    |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>  |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>319 HOMELAND SOUTHWAY APT. 2A.</b> |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL DRUM</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA HOUSEKNECHT</b>  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO <b>161-34-3294</b>  |  | 17 INFORMANT ADDRESS <b>MRS. RUTH M. RILEY 319 HOMELAND SOUTHWAY APT. 2A.</b>  |  |  |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Cancer</b>   |  |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YR.</b> |
| 1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HASCVD, SH PACEMAKER INSERTION, HOCVA, MI, CATARACTS, CONTRACTIONS</b>  |  |   |  |  |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 24, 1978</b> to <b>MARCH 21, 1981</b> , that (I) (we) last saw the deceased alive on <b>MARCH 13, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |   |   |
| 22b. SIGNATURE <b>John A. Nesbitt III MD</b> DEGREE <b>MD</b>   |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>3/22/81</b>                           |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN A. NESBITT 3rd</b>  |  |   |  |  | 22e. ADDRESS <b>201 E. UNIVERSITY PARKWAY 21218</b>  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>MAR. 27, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CONYNGHAM CEM.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>CONYNGHAM LUZERNE PENNA.</b>                      |   |   |   |
| 24 FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. BALTIMORE MD.</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE  |   |   |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81

06719

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                          |   |  |  |  |  |  |
|--|--|--|---|---|--------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Louis Banks</b>   |  |  | 2a. DATE OF DEATH<br>MONTH / DAY / YEAR<br><b>3 / 27 / 81</b> |   | 2b. HOUR<br><b>205</b> M |   |  |  |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>B</b>  |   | 5. DATE OF BIRTH<br>MONTH / DAY / YEAR<br><b>08 / 12 / 13</b>   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS / DAYS   |  | IF UNDER 24 HRS<br>HOURS / MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baet.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baet.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baet. City Hosp.</b> |   |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baet.</b> 13c. CITY OR TOWN <b>Baet.</b>  |  |  |   |   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>649 N. Avondale Rd</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unkn</b>  |  |  |   |   |                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unkn</b>                                    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-0126</b>   |   | 17. INFORMANT<br><b>Amanda Banks</b>  |                          | ADDRESS<br><b>649 N. Avondale Rd</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |                          |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                          |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                          |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>81</b> , to <b>3/27</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |   |   |                          |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ben Jones</b>   |  |  |   |   |                          | DEGREE  |  | 22c. DATE SIGNED<br><b>3/27/81</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ben Jones</b>  |  |  |   |   |                          | 22e. ADDRESS<br><b>Baet. City Hosp.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/31/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk</b>  |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus</b>                                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  |  |   |   |                          | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>  |  | 25b. DATE REC'D. BY REGISTRAR<br><b>3/30/81</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1962-1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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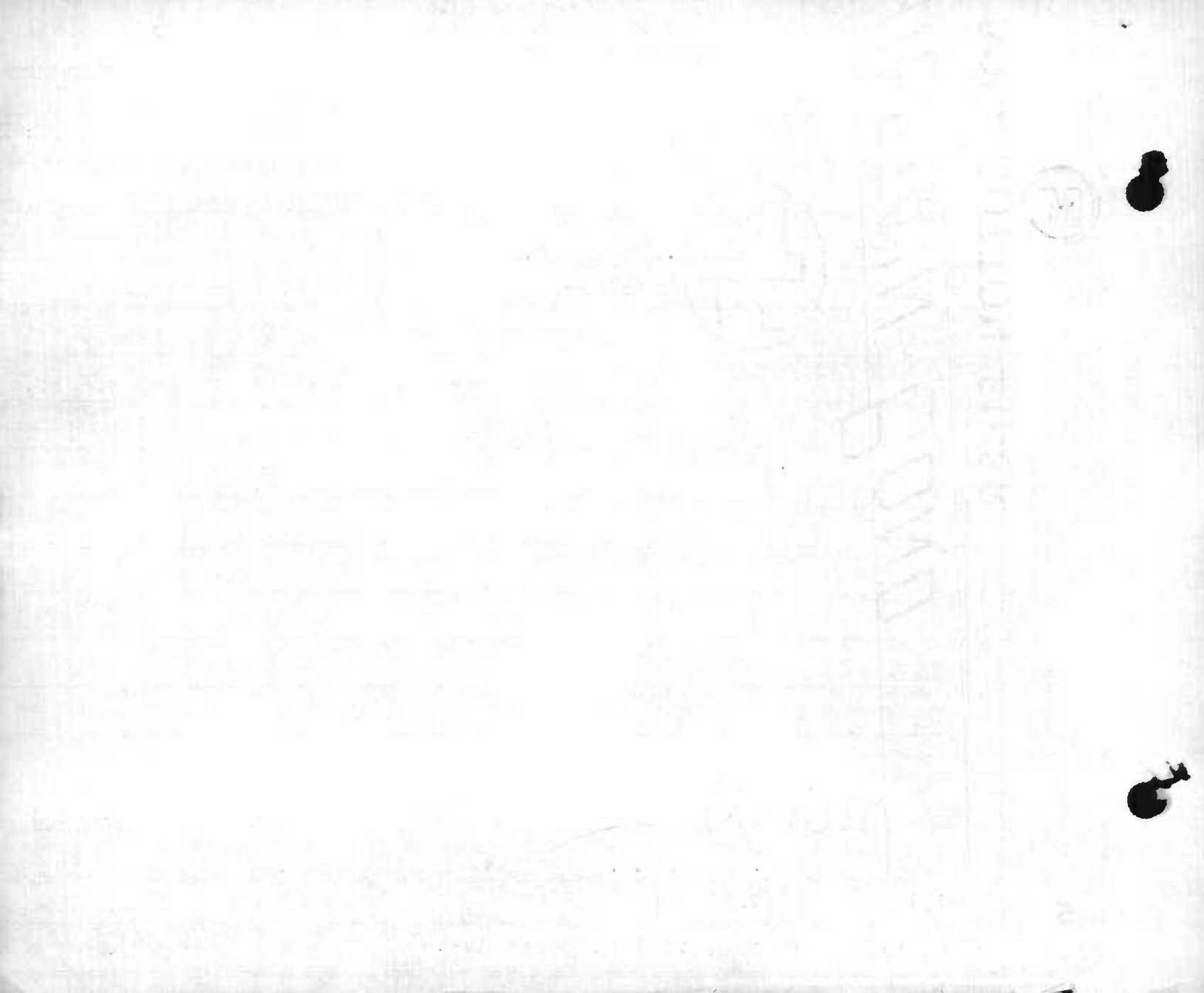
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |   |  |   |  |   |      |   |  |   |  |   |                               |   |  |  |  |
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| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>WILLIAM |   |  | MIDDLE<br>BANKS                                 |  |   | LAST |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3 2 1981 |  |   | 2b. HOUR<br>M<br>12:12<br>P M |   |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>negro |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 2 13 67   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>67 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |      | IF UNDER 24 HRS.<br>HOURS MIN.              |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 2 1981  |  |   | 7d. HOUR<br>P M               |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |                               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2328 W. Fayette St. |  |   |  |   |      |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                       |  |   |                               | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |                  | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |      |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |   |                               | 13e. STREET ADDRESS<br>2328 W. Fayette Street |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Roscoe  |  |                  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene BANKS  |  |   |  |   |      |   |  |   |  |   |                               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                  | (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>214-03-2245   |      |   |  | 17. INFORMANT<br>ADDRESS<br>Mary L. Banks 2328 W. Fayette St.                                       |  |   |                               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |                  |   |  |   |  |   |      |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                               |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |                  |   |  |   |  |   |      |   |  |   |  |   |                               |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |      |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |                               |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |      |   |  |   |  |   |                               |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |   |  |   |  |   |                               |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                  |   |  |   |  |   |      |   |  |   |  |   |                               |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |      |   |  | DATE SIGNED<br>3-2-81   |  |   |                               |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |                  | ADDRESS<br>111 Penn St.   |  |   |  |   |      |   |  |   |  |   |                               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  |                  |                  | 23b. DATE<br>3/7/81   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven  |      |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Anne Arundel Co., MD.                                       |  |   |                               |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C. MARCH F/H INC. ADDRESS<br>1101 E. North Ave.   |  |                  |                  |   |  |   |  |   |      | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1981 |  |   |  | 25b. REGISTRAR'S SIGNATURE<br> |                               |   |  |  |  |

2002



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8106721  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Dorothy Barber</u>   |  |  |  | 2a. DATE OF DEATH MONTH <u>3</u> DAY <u>10</u> YEAR <u>81</u> 2b. HOUR <u>10A</u> M  |  |   |  |
| 3. SEX <u>Female</u>   |  | 4. RACE <u>White</u>   |  | 5. DATE OF BIRTH MONTH <u>6</u> DAY <u>18</u> YEAR <u>13</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD   |  |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>ST. AGNES HOSPITAL</u> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Lineworker</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Western Elect.</u>   |  |
| 13a. STATE <u>Maryland</u>   |  | 13b. COUNTY <u>Baltimore</u>   |  | 13c. CITY OR TOWN <u>Lansdowne</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <u>Delbert</u> MIDDLE <u>Willey</u> LAST <u>Willey</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <u>Florence</u> MIDDLE <u>Harkens</u> LAST <u>Harkens</u>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS <u>Charles B. Barber A24-Holliday Estate</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Failure (uremia)</u><br>4039<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF -<br>(b) <u>Generalized Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF -<br>(c) <u>Hypertension</u><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>19</u> DAY <u>19</u> P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Victor Jaworsky</u> DEGREE   |  |  |  | 22c. DATE SIGNED <u>3/10/81</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Victor Jaworsky</u>   |  |  |  | 22e. ADDRESS <u>900 Caton Ave, Baltimore, MD</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>3/13/81</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>   |  | 23d. LOCATION CITY OR TOWN <u>Baltimore City</u> COUNTY <u>Maryland</u> STATE   |  |
| 24. FUNERAL DIRECTOR NAME <u>Ambrose, Inc. 1328 Sulphur Spring Rd.</u> ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <u>MAR 12 1981</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |   |  |  |  |  |   |  |
|---|--|---|--|---|--|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Grace Barbour</i>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3 1 81</i>                      |  |   |  | 2b. HOUR<br><i>7 AM</i>  |  |  |   |  |
| 3 SEX<br><i>F</i>   |  | 4 RACE<br><i>Negro</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3 30 1902</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>78</i>  |   | IF UNDER 1 YEAR MONTHS DAYS<br><i>11 29</i>  |  | IF UNDER 24 HRS. HOURS MIN.<br><i>7 00</i>             |  |   |  |
| 7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto., City</i> MD.                     |   |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto., Md</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Melchor Nursing Home</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Baby Nanny</i> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |
| 13a. STATE<br><i>MD</i>   |  |   |  |   | 13b. COUNTY<br><i>Balto.</i>   |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><i>1035 Lanvale St</i> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Joseph Barbour</i>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Susanna R. Butler</i> |  |   |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>  |  |   |  |   | 16b. SOCIAL SECURITY NO<br><i>219-30-1721A</i>                         |  | 17. INFORMANT NAME AND ADDRESS<br><i>Theresa Ramey 3047 Vista St.<br/>N.E. Washington</i> |  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>respiratory arrest</i><br><i>2754</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>hypertension</i>   |  |   |  |   |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><i>N/A</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>N/A</i>  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>N/A 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>N/A</i>  |  |  |   |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>N/A</i>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/1 19 81</i> to <i>3/1 19 81</i> , that (I) (we) lost<br>saw the deceased alive on <i>2/27 19 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN<br><i>M. Sharoky MD</i>   |  |   |  |   | DEGREE<br><i>MD</i>  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>3/1/81</i>                            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>McLwin Sharoky</i>  |  |   |  |   | 22e. ADDRESS<br><i>1205 St Paul St</i>                                 |  |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>3/6/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>                            |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>WM.C. MARCH F/H INC.</i>  |  |   |  |   | ADDRESS<br><i>1101 E. North Ave</i>                                    |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 4 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Sharoky</i> |  |   |  |



235 8997



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 06723  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Eugene Russell Barker  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH 3 DAY 3 YEAR 1981 |  |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White                       |  | 5. DATE OF BIRTH<br>MONTH 4 DAY 19 YEAR 1895  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) 87 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH 3 DAY 3 YEAR 1981                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>975 North Hill Road                           |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>M.D.   |  |  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>BALTO.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>975 North Hill Rd.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Eugene Barker   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Emily  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) yes  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-07-604  |  | 17. INFORMANT<br>CRAINE Huetger  |  |   |  | ADDRESS<br>SAME   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                    |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE Virginia L. Dolan MD  |  |  |  | TITLE (SPECIFY) M.D. Assistant  |  |  |  | DATE SIGNED 3/3/81  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |  |  | ADDRESS 111 Penn Street, Baltimore, MD. 21201   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION  |  |  |  | 23b. DATE 3/11/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CITY M.D.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME Redd Funeral Home  |  |  |  | ADDRESS 5209 York Rd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR MAR 9 1981  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |  |  |  | 8   | 1 | 0   | 6                                 | 7  | 2  | 4   |   |  |
|---|--|--|---|--|--|---|--|--|--|---|---|---|-----------------------------------|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  |   |  |  |  | REG. NO.  |   |   |                                   |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine Barnes</b>   |  |  |   |  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 5, 1981</b>                           |   |   |                                   | 2b. HOUR<br><b>8:30a</b><br>M  |  |   |   |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Black</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-1-25</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b><br>YRS.                 |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LANCASTER SC.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b><br>MD. |   |   |   |                                   |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Wife</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |   |  |  |   |  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1614 McCullough Street</b><br><b>Balt. Md 21217</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie B. Ballard</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Cunningham</b>  |  |  |   |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>         |   |   |                                   |  | 16b. SOCIAL SECURITY NO.<br><b>578-38-5769</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Louise B McGill 314 P St North West Washington, DC</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>(Clinical) Cerebral Infarct</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mild Atherosclerotic cardiovascular disease</b><br>DOE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |                                   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Chronic Obstructive Pulmonary disease</b>   |  |  |   |  |  |   |  |  |  |   |   |   |                                   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |   |   |   |                                   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |   |                                   |  |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 10, 1981</b> , to <b>March 5, 1981</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 5, 1981</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |   |   |   |                                   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Craig R Martin</b><br>DEGREE <b>MD</b>   |  |  |   |  |  |   |  |  |  | 22c. DATE SIGNED<br><b>2/5/81</b>   |   |   |                                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig Martin, M.D.</b>  |  |  |   |  |  |   |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                                  |   |   |                                   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |   | 23b. DATE<br><b>3-10-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANNE ARUNDEL Co. MD.</b>             |   |   |                                   |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William J. Spicer</b><br>ADDRESS<br><b>1637 N. Broadway</b>  |  |  |   |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>                                   |   |   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Ray McHenry</b>   |  |   |   |  |

100-301

Bellevue Hospital

Bellevue

(Clinical) General Internal

His (2) - roscheria & roscheria disease

Chronic obstructive pulmonary disease

XX

February 1971

March 1971

March 1971

XX

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 2 5

13  
1- FOR  
STATE  
REGISTRAR

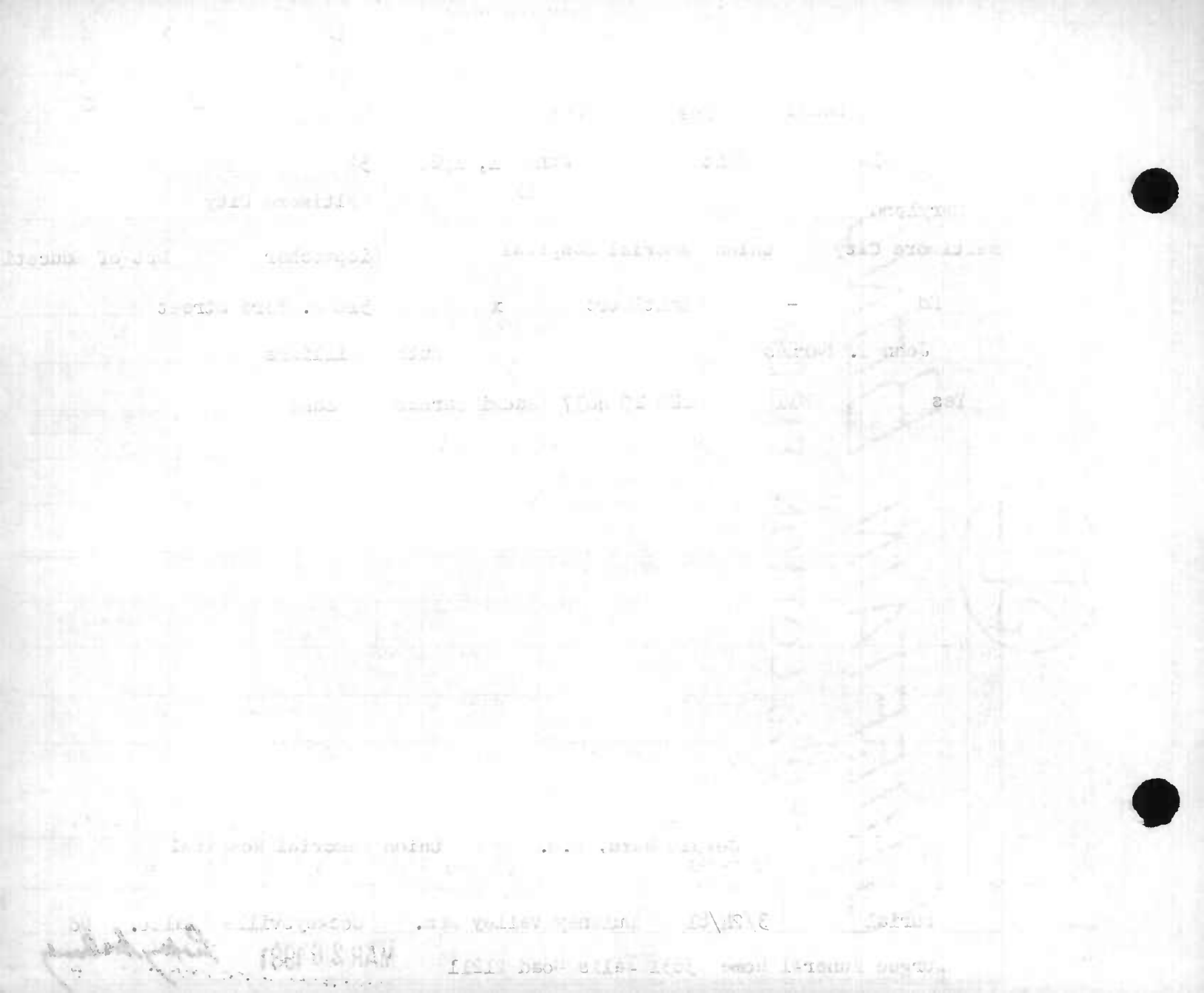
REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Donald Lee Barnes</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 21 81</b>                                |   | 2b. HOUR<br><b>2<sup>30</sup> P.M.</b>                           |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1, 1928</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dispatcher</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dpt of Education</b>     |
| 13a. STATE<br><b>Md</b>  |   | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John T. Barnes</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Williams</b>                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Naomi Barnes Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA, UNKNOWN PRIMARY</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MONTHS</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <del>no</del> (this hospital) attended the deceased from <b>3/14/81</b> , 19____, to <b>3/21/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/21/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Jerald Ward</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>3/21/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JERALD WARD</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/24/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto. Md</b>  |   | 23e. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 26 1981</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b>   |   |   | ADDRESS<br><b>3631 Falls Road 21211</b>   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



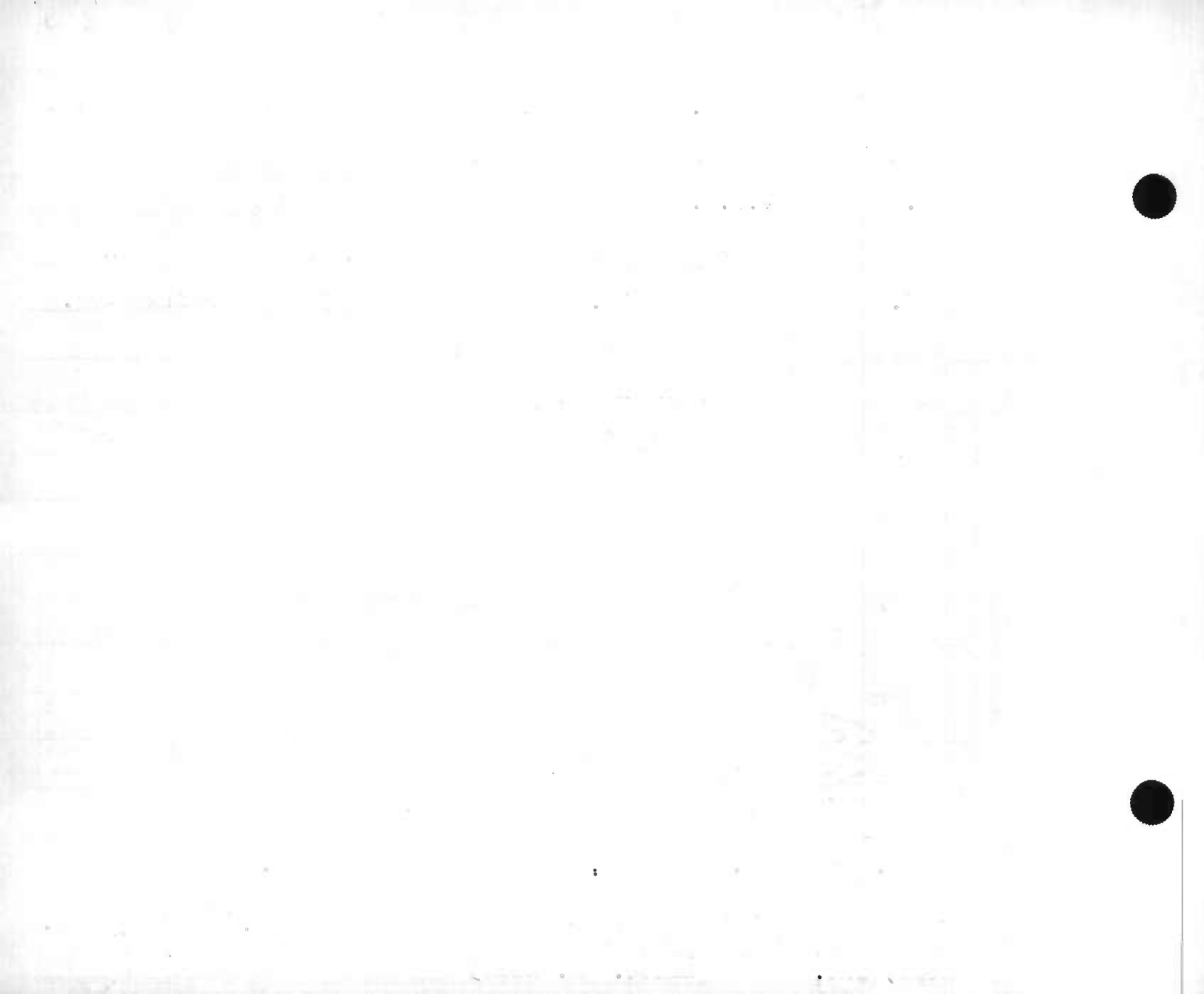
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |   |   |  | 8  | 1                          | 0 | 6 | 7        | 2 | 6 |
|---|--|--|--|---|--|---|---|---|--|--|----------------------------|---|---|----------|---|---|
| FOR<br>STATE<br>REGISTRAR   |  |  |  |   |  |   |   |   |  | REG. NO.                                     |                            |   |   |          |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |   | FIRST MIDDLE LAST                          |   |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR             |                            |   |   | 2b. HOUR |   |   |
| Gladys K. Barnes  |  |  |  |   |  |   |   |   |  | March 3, 1981                                |                            |   |   | 3 AM     |   |   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN. |   |   |          |   |   |
| Female  |  | Caucasian  |  | Jul 28 1906   |  |   | 74 YRS.   |   |  |  |                            |   |   |          |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |  |                            |   |   |          |   |   |
| Md.   |  | U.S.A.   |  |   |  |   | Baltimore City MD   |   |  |  |                            |   |   |          |   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                            |   |   |          |   |   |
| Baltimore   |  | Union Memorial Hospital  |  |   |  |   | Homemaker   |   |  |  |                            |   |   |          |   |   |
| 13a. STATE  |  |  |  |   | 13b. COUNTY                                |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS        |   |   |          |   |   |
| Md.   |  |  |  |   |  |   | Balto.  |   |  |  | 3133 Chesterfield Ave.     |   |   |          |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |   |   |   |  |  |                            |   |   |          |   |   |
| William Craig   |  |  |  |   | Martha                                     |   |   |   |  |  |                            |   |   |          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |   | 16b. SOCIAL SECURITY NO.                   |   | 17. INFORMANT ADDRESS   |   |  |  |                            |   |   |          |   |   |
| no  |  |  |  |   | 212-74-2462                                |   | Robert Barnes (husband) same address                          |   |  |  |                            |   |   |          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.   |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |   |   |          |   |   |
| 4100 IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>  |  |  |  |   |  |   |   |   |  | stat   |                            |   |   |          |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| 19a. DATE OF OPERATION <u>12/18</u>   |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  |                            |   |   |          |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |                            |   |   |          |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |                            |   |   |          |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> 19 <u>72</u> , to <u>3/3</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death. |  |  |  |   |  |   |   |   |  |  |                            |   |   |          |   |   |
| 22b. SIGNATURE <u>Melvin F. Polek, M.D.</u> DEGREE  |  |  |  |   |  |   |   |   |  | 22c. DATE SIGNED <u>3/5/81</u>               |                            |   |   |          |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  |   |   |   |  | 22e. ADDRESS                                 |                            |   |   |          |   |   |
| Dr. Melvin F. Polek Sr.   |  |  |  |   |  |   |   |   |  | 3603 Belair Rd.                              |                            |   |   |          |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |                            |   |   |          |   |   |
| Burial  |  |  |  | 3/6/81  |  | Parkwood  |   | Balto.                                  |  | Md.  |                            |   |   |          |   |   |
| 24. FUNERAL DIRECTOR  |  |  |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE              |  |  |                            |   |   |          |   |   |
| Sealmanek Funeral Home, Inc.  |  |  |  | 3331 Brehms Lane Balto. Md. 21213   |  | MAR 6 1981  |   | <u>Melvin F. Polek</u>                  |  |  |                            |   |   |          |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |   |  |
|--|--|--|--|---|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8106727   |   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>VIOLA MARY BARNES</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 28 1981</b>             |   |  | 2b. HOUR<br><b>6 <sup>50</sup> A. M.</b>  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 18 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>70</b>                                      |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cafeteria Wkr</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Goetz Co.</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>5820 Moores Run Ct. 21206</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Green</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Martha Krug</b> |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-6336</b>   |  | 17. INFORMANT ADDRESS<br><b>Joanna Boniface 5820 Moores Run Ct.</b>   |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1830 TERMINAL CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OVARY (endometrial) 2 years</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>= Metases.</b>  |  |  |  |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>— Baltimore</b>  |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-22</b> , 19 <b>81</b> , to <b>3-28</b> , 19 <b>81</b> , that (I) (we) lost <b>saw the deceased alive on 3-28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |   |  |
| 22b. SIGNATURE <b>Nashat N. Ateia</b>  |  |  |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3-28-1981</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NASHAT N. ATEIA</b>  |  |  |  | 22e. ADDRESS<br><b>THE UNION MEMORIAL HOSPITAL</b>  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/31/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>3331 Brehms La. 21213</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>31 MAR 31 1981</b>                                   |  |   |   |  |



THE UNION NATIONAL BANK

NEW YORK

NEW YORK, N.Y. 10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |   | 8 1 0 6 7 2 8   |   |   |  |  |   |  |
|--|--|--|---|---|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO.  |   |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ADDIE BARNWELL</b>  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3/12/81</b>                    |   |   |  |  | 2b. HOUR<br><b>11:00 AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 10 05</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 72 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MULLINS S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Toy Factory</b>  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |   |   |   |  |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3930 DUVAL AVE</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARCH LIVINGSTON</b>   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA MCJURKIE</b> |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>074-16-2430</b>                        |   | 17. INFORMANT ADDRESS<br><b>ALVIN BARNWELL Apt-11-C<br/>200 W. 147 St New York N.Y. 10039</b> |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>5779</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypotension, Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Pancreatic Failure/Necrosis, Fungicemia, Renal Failure, Liver Failure</b> |  |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b><br><b>12 Days</b><br><b>20 Days</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>3-1-81</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>? Bowel Infarction</b> |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2-5-81</b> , 19 <b>81</b> , to <b>3-12</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>3-12</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Roger E. Schneider</b>  |  |  |   |   |   | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-12-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roger E. Schneider MD</b>  |  |  |   |   |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital, Baltimore MD</b>                                     |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |  | 23b. DATE<br><b>3-12-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Plot</b>              |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mullins S.C.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall D. Hayes 638 W. E. Mon St</b>  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of place.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 2 9

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLAYBORN BARTLEY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 81</b>                 |   |  | 2b. HOUR<br><b>1:15p</b>  |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 27 92</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>537 N. LONGWOOD ST 21223</b>                               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RICHARD BARTLEY</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SALLY WILKINS</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218054536</b>  |   | 17. INFORMANT ADDRESS<br><b>VAMC MEDICAL RECORDS 3900 LOCH RAVEN BLVD</b>                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atrial and Ventricular Arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Previous stroke, Congestive Heart Failure</b>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>MARCH 2</b> , 19 <b>81</b> , to <b>MARCH 14</b> , 19 <b>81</b> , that (X) (we) lost saw the deceased alive on <b>MARCH 18</b> , 19 <b>81</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (Y) (we) (did) (not) view the body after death.                                  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>E. T. Souweine</b>   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/15/81</b>                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. T. Souweine</b>  |  |   |   | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD BALTO, MD 21218</b>                                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-19-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br><b>ELIZABETH PHILLIPS 1721 N. MONROE ST.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 17 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry A. Brady</b>                     |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>CLIFFORD E. BAUBLITZ</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAR 8 1981</b>               |   |  | 2b. HOUR<br>M  |  |  |  |
| 3 SEX<br><b>M</b>  |  | 4 RACE<br><b>W</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/25/34</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1209 WOHLER WAY</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAPER CO</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>+</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1209 WOHLER WAY</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN BAUBLITZ</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HELEN COLLINS</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218 28 7398</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>CHARLOTTE BAUBLITZ ABOVE</b>  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Adeno Ca</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Primary site unknown.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>? mo's.</b> |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-23-81</b> to <b>3-6-81</b> , that (I) (we) last saw the deceased alive on <b>3-6-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Vikas Saini</b>   |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-10-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VIKAS SAINI</b>  |  |   | 22e. ADDRESS<br><b>4940 Eastern Ave, Balt MD</b>                       |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/11/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAWN</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CITY</b> |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>  |  |   | ADDRESS<br><b>300 MACE</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a FilmG554 4/28/81

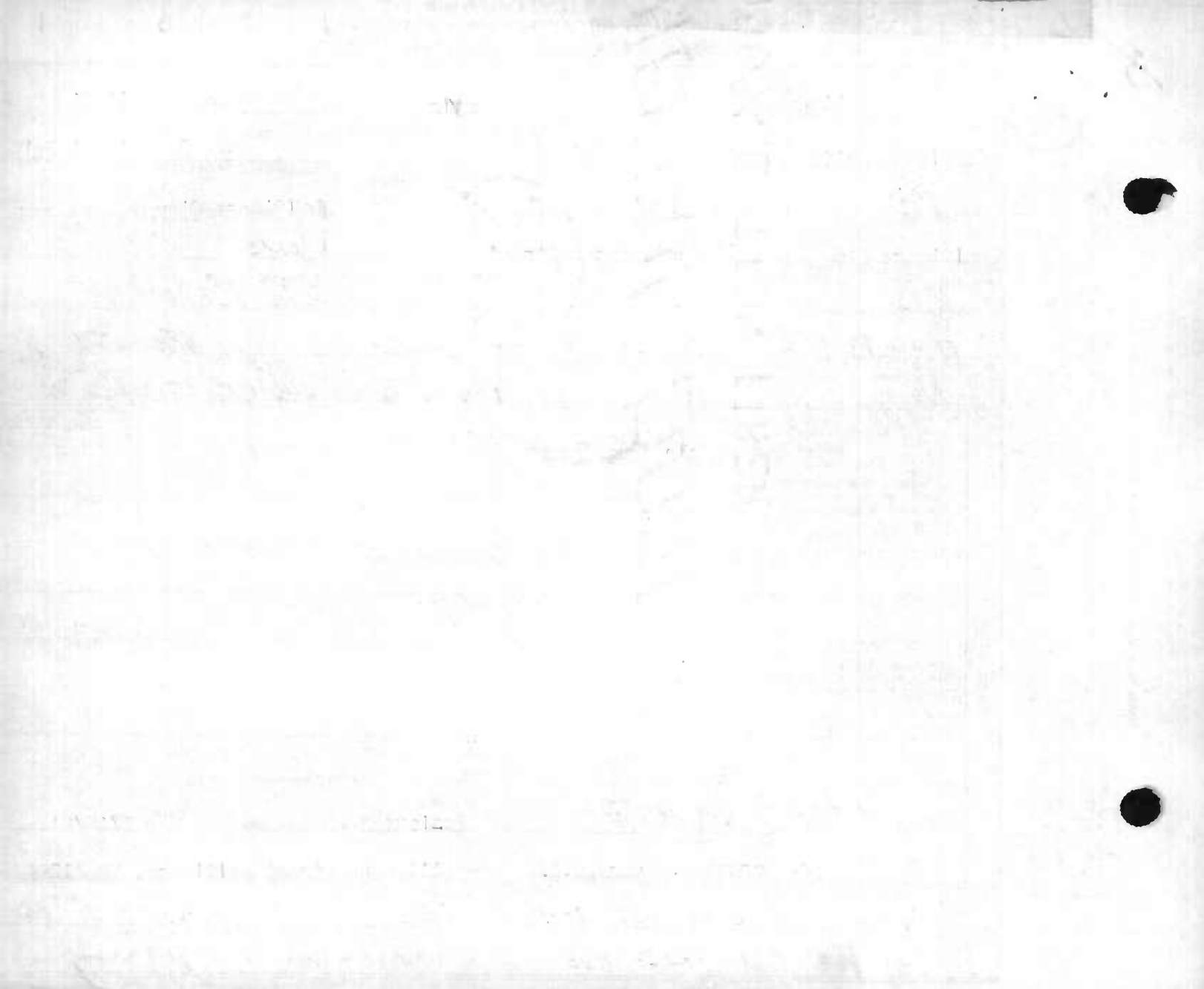
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06731

|  |  |                      |  |  |  |   |  |   |  |
|--|--|----------------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Linda C. Bavis   |  |                      |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3 14 81   |  |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>female   |  | 4. RACE<br>White     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR JUNE 18 1956  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) 24 YRS.                                    |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>615 South Macon Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE   |  |
| 13a. STATE<br>MD.  |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST FRANCIS L. BAVIS JR.  |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST ALMA MOUNTS  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No   |  |                      |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS 21723 Francis Bavis 14610 MONTICELLO DR.               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>8589 IMMEDIATE CAUSE (a) Multiple drug intoxication<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                      |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a   |  |                      |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) X |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Dr. Hormez R. Guard, M.D.  |  |                      |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>3/15/81  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Dr. Hormez R. Guard, M.D.   |  |                      |  | ADDRESS 111 Penn Street Baltimore, MD 21201  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>3-20-81 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. JOHN'S CEM.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE Howard Co. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME HARLEY F.H. 6601 PRED AVE. ADDRESS  |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1981   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH.

8106732

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Issac Baylis   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 4 81                                |   | 2b. HOUR<br>2:10p M   |
| 3. SEX<br>Male   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 14 28  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware                      | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONSTRUCTION |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Balto  | 13c. CITY OR TOWN<br>Balto   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1347 Ward St                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARVAY Bethards                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LeHlis Baylis  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-240849   |  | 17. INFORMANT<br>ADDRESS<br>ISAAC Baylis Jr. 1347 Ward St.                                      |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary arrest<br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) unknown<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET  | CITY OR TOWN COUNTY STATE   |

22a. I certify that (I) (this hospital) attended the deceased from 1:43 pm 3/4, 19 81, to 2:10 pm 3/4, 19 81, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |        |  |                            |
|---|--------|--|----------------------------|
| 22b. SIGNATURE<br>DE Kelley                             | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>3/4/81 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David E Kelley |        | 22e. ADDRESS<br>22 S. Green St., Balto., MD  |                            |

|  |                       |   |   |
|--|-----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>3-9-1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md |
| 24. FUNERAL DIRECTOR<br>NAME<br>BROWN-Thompson F.N.    |                       | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981       | 25b. REGISTRAR'S SIGNATURE<br>P. Thompson               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 1 0 6 / 3 3  |  |  |  |   |
|---|--|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Alvin F. Baytons   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 31 81                    |  |  |  | 2b. HOUR<br>7:30 P.M.                             |
| 2. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 7 16  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, Md. - City MD.                    |  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Baltimore                                       |  | 13c. CITY OR TOWN<br>Baltimore                                   |  | 13d. STREET ADDRESS<br>103 Allendale St. - Balto. |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Willie Baytons  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Gaines |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) Yes  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>WWII 139-16-1955                   |  | 17. INFORMANT<br>Wife 103 Allendale St. - Balto. #21229          |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LEIOMYOSARCOMA OF STOMACH WITH METASTASES<br>1719<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 YEARS |  |   |  |   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>NONE   |  |   |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION<br>8/19/79   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>180                |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 AUGUST, 19 80 to 31 MAR, 19 81, that (I) (we) lost saw the deceased alive on 31 MAR, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br>WKGALLAGER JR MD  |  |   | DEGREE<br>MD   |   |  | 22c. DATE SIGNED<br>31 MAR 81  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WKGALLAGER JR MD   |  |   | 22e. ADDRESS<br>3455 WILKENS AVE, BALTO, MD 21229                      |   |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>4/4/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  |   | ADDRESS<br>1101 E. North Ave   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 2 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |

M

*[Handwritten signature]*

APR 5 1991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | 8 1 0 6 7 3 4  |  |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |   |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET Ellen BEALL</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> / DAY <b>16</b> / YEAR <b>81</b>        |  | 2b. HOUR<br><b>1:23 P.M.</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>August</b> / DAY <b>19</b> / YEAR <b>1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                                | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>2112 St. Paul Street</b>   |
| 14. FATHER'S NAME<br>FIRST <b>Albert</b> MIDDLE LAST <b>Horack/Harck</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Stella</b> MIDDLE LAST <b>Krbausel</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-07-5283</b>  |   | 17. INFORMANT <b>Step-daughter</b> ADDRESS<br><b>Cecilia B. Trott, 1612 N. Poplar Ave. Annapolis, MD 21401</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> 19 <b>81</b> to <b>3/16</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/16</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>David M. Fishbein M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   |   |   | 22c. DATE SIGNED<br><b>3/16/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David M. Fishbein M.D.</b>   |   |   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL<br/>DAVID M. FISHBEIN, M.D.</b>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3/19/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Annapolis, A. A. Co., MD</b> COUNTY STATE                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>STEWART &amp; MOWEN CO., 108 W. North Ave. 21201</b> ADDRESS  |   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1981</b> REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>             |  |

King

To

August 10, 1952

White

Thomas

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1.2.1.

None

2115 St. Paul Street

x

Chilmore

Chilmore

Albany

Albany

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Albany

Albany, N.Y. 12205

Albany, N.Y. 12205

Albany, N.Y. 12205

Albany, N.Y. 12205

Albany

NO

St. Mary's University

Albany

Albany

STANT & HORN CO., 108 E. North Ave., 12201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8106735   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Lottie - Beauchamp</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>March 12 1981</b> 2b. HOUR <b>9:25 P.M.</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 12 99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital of Baltimore</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 13a. STATE <b>Md</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore City</b>  |  | 13d. STREET ADDRESS <b>1600 W. Mt. Royal Ave.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Lawrence Aro</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Arnett</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO. <b>216-52-7164</b>  |  | 17. INFORMANT ADDRESS <b>Mr. Otis Beauchamp Same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4349</b> IMMEDIATE CAUSE (a) <b>Massive pontine infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/28 19 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>2/28 19 81</b> to <b>3/12 19 81</b> , that (I) (we) last saw the deceased alive on <b>3/12 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Diana B. Rivera - Cester</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>3/12/81</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Diana B. Rivera - Cester</b>  |  |   |  | 22e. ADDRESS <b>Sinai Hospital of Baltimore</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Mar. 16, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Maryland</b> ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1981</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4 to the Police Department and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8  | 1 | 0                              | 6 | 1   | 3 | 6                                       |  |
|--|--|---|--|---|--|---|--|--|--|--|---|--------------------------------|---|---|---|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.   |   |                                |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HUGO M. BECK  |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 4, 1981   |   |                                |   | 2b. HOUR<br>2:20AM  |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |   |                                |   |   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wisconsin   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |  |  |  |  |   |                                |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mathematician |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Fed. Gov't.                                     |  |  |   |                                |   |   |   |   |  |
| 13a. STATE<br>Md.  |  |   |  |   |  |   |  |  |  | 13b. COUNTY<br>Pr. Geo.  |   | 13c. CITY OR TOWN<br>Oxon Hill |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>8100 Neville Pl. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur J. Beck   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Winifred Roessler |   |  |  |  |  |   |                                |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no none  |  |   |  | 16b. SOCIAL SECURITY NO.<br>398-01-0493   |  | 17. INFORMANT ADDRESS<br>Lorraine Beck same as item #13                           |  |  |  |  |   |                                |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HYPERCALCEMIA</u><br>2030<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE MYELOMA, END STAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |  |  |  |   |                                |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |  |  |  |  |   |                                |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |   |                                |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |  |   |                                |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/20/81</u> , 19____, to <u>3/4/81</u> , 19____, that (I) (we) lost saw the deceased alive on <u>3/4/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) _____ the body after death.  |  |   |  |   |  |   |  |  |  |  |   |                                |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Stephen A. Cannistra</u>  |  |   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>3/4/81</u>  |  |  |   |                                |   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEPHEN A. CANNISTRA</u>   |  |   |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>   |  |   |  |  |  |  |   |                                |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>3/7/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cemetery                       |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton P.G. Md.   |   |                                |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.   |  |   |  | ADDRESS<br>MAY 5 1981   |  |   |  | 25. REGISTRAR'S SIGNATURE<br>D. BY REGISTRAR   |  |  |   |                                |   |   |   |   |  |

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It will be a real pity.

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4. Kateri so bili glavni vzroki za nastanek konflikta?

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8106137   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>RAITHER R BECKWITH</b>   |  |  |  | MONTH DAY YEAR HOUR<br><b>3 31 81 4:55a.m.</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 16 56</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>24</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PAINTER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT BECKWITH</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JACQUELINE TROXELL</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212785920</b>   |  | 17. INFORMANT ADDRESS<br><b>VAMC MEDICAL RECORDS 3900 LOCH RAVEN BLVD</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenocarcinoma of Colon</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Familial Polyps, Gardner's Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 25</b> , 19 <b>81</b> , to <b>MARCH 31</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>D. Cook MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/31/81.</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. Cook MD</b>   |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>4/1/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAK LAWN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. M.D.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.E. CONNELLY</b>   |  | ADDRESS<br><b>300 MALE</b>   |  | 25. BY REGISTRAR<br><b>APR 1 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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## CREATIVITY

ENCLOSURE

# CLAYTON

TABLE 6-1

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00000000000000000000000000000000

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |         |   |   |  |   |   |                          |  |
|---|---------|---|---|--|---|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |                          |  |
| FIRST MIDDLE LAST<br>CHARLOTTE M. BEEHLER   |         |   | MONTH DAY YEAR<br>3-1-81  |  |   | 6 <sup>15</sup> A.M.  |                          |  |
| 3 SEX   | 4. RACE | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR  |                          |  |
| Female  | White   | MONTH DAY YEAR<br>Jan. 2, 1887  |   | 94 YRS.  |   | IF UNDER 24 HRS.  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                          |  |
| Maryland  |         | USA   |   |  |   | Baltimore City MD.  |                          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                          |  |
| Baltimore   |         | 101 N. Bond Street  |   | Social Worker  |   | Church  |                          |  |
| 13a. STATE  |         |   | 13b. COUNTY   |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? |  |
| Maryland  |         |   | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |   | 13e. STREET ADDRESS      |  |
| 14. FATHER'S NAME   |         |   | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |   |                          |  |
| FIRST MIDDLE LAST<br>Charles E. Beehler   |         |   | FIRST MIDDLE LAST<br>Charlotte Meixsal                              |  | No  |   |                          |  |
| 16b. SOCIAL SECURITY NO.  |         |   | 17. INFORMANT   |  | ADDRESS   |   |                          |  |
| 220 46 6747   |         |   | George H. Beehler, Jr., Balto., Md.                                 |  |   |   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |         |   |   |  |   |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>   |         |   |   |  |   |   |                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |         |   |   |  |   |   |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC RENAL FAILURE</u>   |         |   |   |  |   |   |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |         |   |   |  |   |   |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |   |   |  |   |   |                          |  |
| 19a. DATE OF OPERATION  |         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY?   |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |         |   |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         |   | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |   |                          |  |
|   |         |   | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  |   |   |                          |  |
| 21d. INJURY OCCURRED  |         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION   |   |                          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |   |   |  | STREET CITY OR TOWN COUNTY STATE  |   |                          |  |
| 22a. I certify that (this hospital) attended the deceased from <u>8/1</u> , 19 <u>77</u> , to <u>3/1</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>3/1</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |         |   |   |  |   |   |                          |  |
| 22b. SIGNATURE  |         |   | DEGREE  |  |   | 22c. DATE SIGNED  |                          |  |
| <i>Gaspar Dei Monte</i>   |         |   |   |  |   | 3/1/81  |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         |   | 22e. ADDRESS  |  |   |   |                          |  |
| GASPAR DEI MONTE MD.  |         |   | Church Home, Inc., Balto., Md.                                      |  |   |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION            |  |
| Burial  |         |   | 3/3/81  |  | Loudon Park   |   | Balto., Md.              |  |
| 24. FUNERAL DIRECTOR  |         |   | 25a. DATE REC'D. BY REGISTRAR                                       |  |   | 25b. REGISTRAR'S SIGNATURE  |                          |  |
| NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |         |   | MAR 2 1981  |  |   | <i>Anthony McCreedy</i>   |                          |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Charles

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George H. Eeshler, Jr., Baltimore, Md.

14

18/3/8

Figure 2

Henry W. Jenkins & Sons Co.

305 York Road, Bldg. 10, Mt. Airy, N.C. 27551



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |                   |   |  |  |  | REG. NO.           |  |          |  |
|--|--|--|--|---|-------------------|---|--|--|--|--------------------|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH |   |  |  |  | MONTH DAY YEAR     |  | 2b. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH |   |  |  |  | MONTH DAY YEAR     |  | 2b. HOUR |  |
| NETTIE Rebecca BELL  |  |  |  |   | MARCH 06, 1981    |   |  |  |  | 10:25 PM           |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                           |  | 8. IF UNDER 24 HRS |  |          |  |
| Female   |  | White  |  | Mar. 10 1926  |                   | 54  |  | MONTHS DAYS                                  |  | HOURS MIN          |  |          |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN)  |  | 9b. CITIZEN OF WHAT COUNTRY?   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |                   | 11. BALTIMORE CITY OR COUNTY OF DEATH                               |  |  |  |                    |  |          |  |
| Jefferson Co.  |  | U.S.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                   | BALTIMORE CITY  |  |  |  |                    |  | MD.      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (IF OTHER THAN USUAL, GIVE WORKING LIFE)  |                   | 12b. KIND OF BUSINESS OR  |  |  |  |                    |  |          |  |
| Baltimore  |  | THE JOHNS HOPKINS HOSPITAL   |  | Secretary   |                   | Health Dept.  |  |  |  |                    |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |                   | 13d. STREET ADDRESS   |  |  |  |                    |  |          |  |
| W.Va.  |  | Jefferson  |  | Charles Town  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 408 Jefferson Ave.                           |  |                    |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN) |                   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  |                    |  |          |  |
| Robert Lee   |  | Margaret S. Writt  |  | No  |                   | 234-36-5943   |  | Leon Bell                                    |  |                    |  |          |  |
| 18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 18b. IMMEDIATE CAUSE (a)   |  | 18c. DUE TO, OR AS A CONSEQUENCE OF (b)   |                   | 18d. DUE TO, OR AS A CONSEQUENCE OF (c)                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                    |  |          |  |
| 1809   |  | CARDIO-PULMONARY ARREST  |  |   |                   |   |  | X  |  |                    |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | TOTAL PELVIC EXENTERATION  |  |   |                   |   |  |  |  |                    |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                    |  |          |  |
| SMARCH 81  |  | CANCER OF CERVIX   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                    |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |   |  |  |  |                    |  |          |  |
|  |  | P.M. 19  |  |   |                   |   |  |  |  |                    |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |                   | CITY OR TOWN  |  | COUNTY                                       |  | STATE              |  |          |  |
|  |  |  |  |   |                   |   |  |  |  |                    |  |          |  |
| 22a. I certify that (1) (this hospital attended to deceased from 2/22 81, to 6 MARCH 81, that (1) lost saw the deceased alive on 6 MARCH 81, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (did) not view the body after death. |  | 22b. SIGNATURES  |  | 22c. DATE SIGNED  |                   |   |  |  |  |                    |  |          |  |
|  |  | Michael B. Dillon  |  | 6 MARCH 81  |                   |   |  |  |  |                    |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR   |                   | 22g. REGISTRAR'S SIGNATURE  |  |  |  |                    |  |          |  |
| MICHAEL DILLON   |  | JOHNS HOPKINS HOSPITAL   |  | MAR 12 1981   |                   |   |  |  |  |                    |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION   |  |  |  |                    |  |          |  |
| Burial   |  | Mar. 10, 1981  |  | Edge Hill Cemetery  |                   | Charles Town Jeff. W.Va.  |  |  |  |                    |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |                   |   |  |  |  |                    |  |          |  |
| Douglas R. Snowden   |  | MAR 12 1981  |  |   |                   |   |  |  |  |                    |  |          |  |

burial  
 Mar. 10, 1961 Edge Hill Cemetery  
 Charles Town, W. Va.

Mr. J. H. Miller  
 Director, Johns Hopkins Hospital

SEARCH OF CANCER INDEX  
 FINAL POLICE INVESTIGATION

CARDIO PULMONARY INDEX

to  
 534-36-2943  
 Leon Bell  
 Robert Lee Jackson  
 Margaret  
 2.  
 400 Jefferson Ave.  
 Charles Town, W. Va.

W. Va. Jefferson Charles Town x 400 Jefferson Ave.

Baltimore  
 Jefferson Co. U.S.  
 Female  
 White  
 Mar. 10 1958  
 2A  
 Secretary  
 Health Dept.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>STEPHEN J. BELOVARICH  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 18 81 |   |  | 2b. HOUR<br>11 A M  |   |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 12 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>YUGOSLAVIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MASTER OF ARMS |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>NAVAL ACADEMY  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MICHAEL BELOVARICH  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>KATHERINE LUSENCIC   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>WW II<br>220-05-4245   |  | 17. INFORMANT<br>ADDRESS<br>ANNA J. BELOVARICH 1820 SPENCE ST., 21230   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis, marked</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13, 19 81, to 3/18, 19 81, that (I) (we) lost<br>saw the deceased alive on 3/18, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>William J. Hicken M.D.  |  |  |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>3/19/81   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William J. Hicken M.D.   |  |  |  | 22e. ADDRESS<br>900 CATON AVENUE BALTIMORE MD 21229   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>03-21-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                           |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.  |  |  |  | ADDRESS<br>4107 WILKENS AVE.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>Robert McBrady   |  |

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

NOTICE

W. K. H. L.

600 CATHY AVENUE BALTIMORE MD 21212

BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Thelma Aileen Bender</i>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 31 81</i>  |  | 2b. HOUR<br><i>8:55 PM</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Apr. 22 1931</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>49</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO. CITY</i> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MERCY HOSPITAL</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Meat packer</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Meat packing</i>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Md.</i> 13b. COUNTY <i>Garrett</i>   |  |  |  |   |  | 13c. CITY OR TOWN<br><i>Grantsville</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Norman Bender</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Beulah Yoder</i>   |  | 13e. STREET ADDRESS<br><i>Loutel, Springs Rd.</i>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>214-34-1551</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Norman Bender, Rt. 1, Grantsville, Md.</i>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardio-pulmonary arrest</i><br><i>2780</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>acute renal failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>aspirin</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><i>3-18-81</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>morbid obesity</i>  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>3/31</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/31</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>A Snyder MD</i>   |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3/31/81</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SNYDER</i>   |  |  |  | 22e. ADDRESS<br><i>MERCY HOSPITAL</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>4-3-1981</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cherry Glade Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Accident Garrett Md.</i>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>A Lynn Norman</i>   |  |  |  | ADDRESS<br><i>Grantsville, Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 9 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

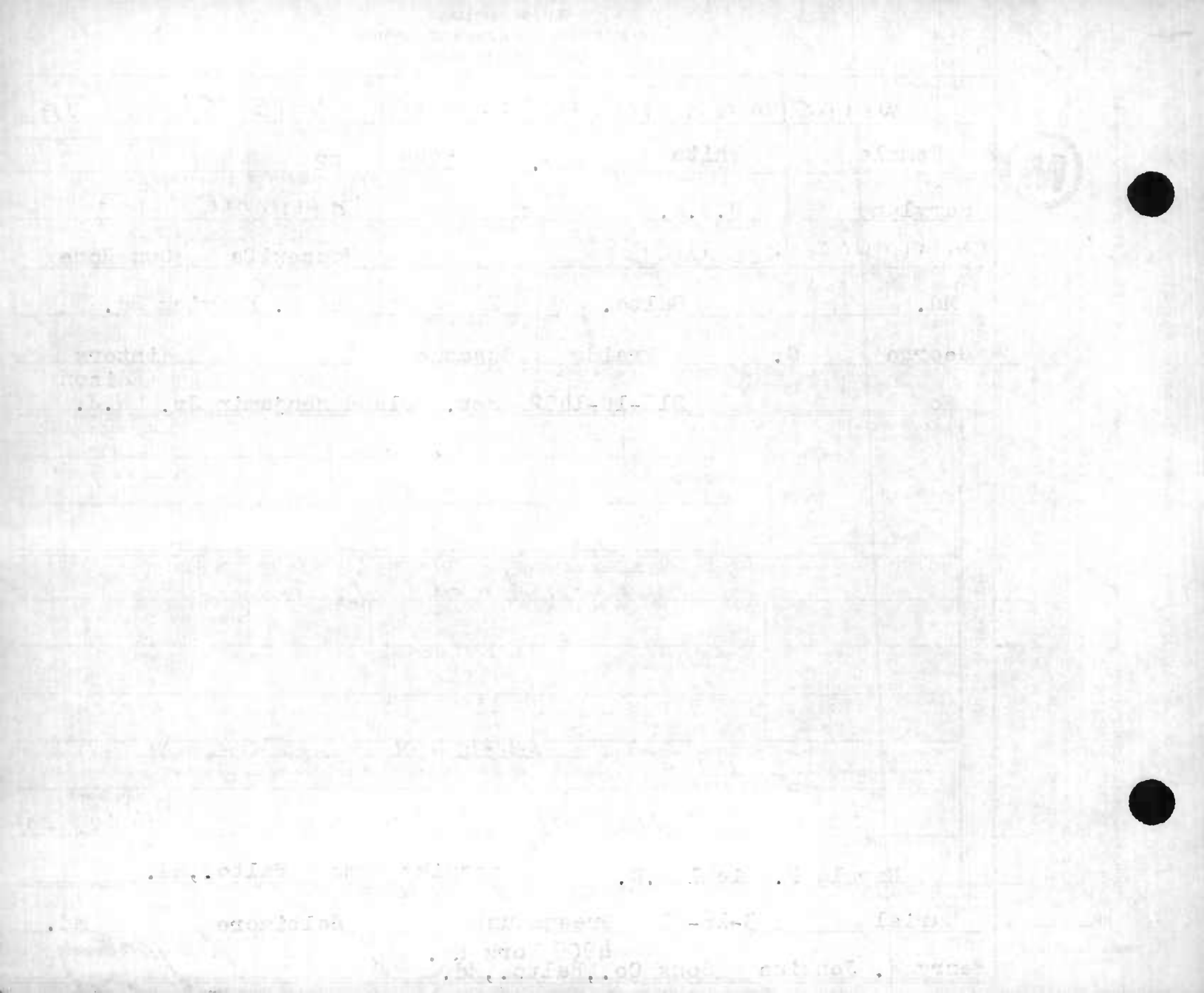
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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | REG. NO. 8106742   |  |   |   |  |
|---|--|---|--|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Wilhelm A Treide Benjamin</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-15-81</b>  |  |   | 2b. HOUR <b>7A</b> M                                    |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9 1888</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Keswick</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |  |   |   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>40 W. Keswick Rd.</b>            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George C. Treide</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susanne Winters</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |  |  | 16b. SOCIAL SECURITY NO. <b>215-10-1492</b>  |  | 17. INFORMANT ADDRESS <b>Rev. Roland Benjamin Jr. N.J.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic CVD</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>3 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Renal disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 MC</b> |  |   |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Urinary tract infection</b>   |  |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4 APRIL 1980</b> to <b>15 MAR 1981</b> , that (I) (we) last saw the deceased alive on <b>15 MAR 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE <b>Harold P. Biehl MD</b> DEGREE <b>MD</b>   |  |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>15 MAR 81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold P. Biehl M.D.</b>   |  |   |  |  | 22e. ADDRESS <b>Keswick Home Balto., Md.</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>3-18-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>                                 |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |  |



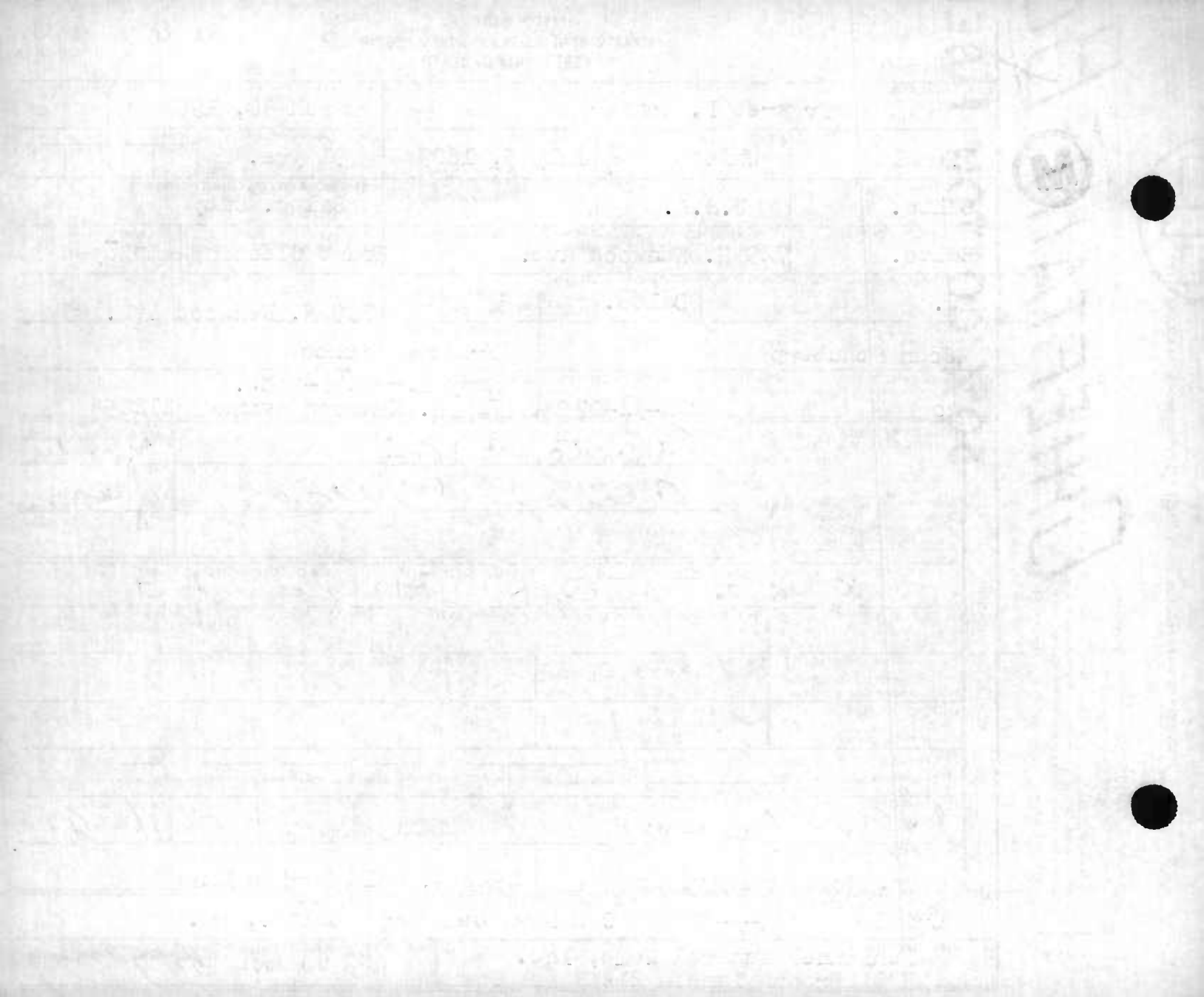




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 1 0 6 7 4 3

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| Margaret F. Benser  |  |  |  | March 30, 1981   |  | M   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  |
| Female  | White  | July 5, 1889   |  | 91 yrs.  |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Balto.  | U.S.A.   |  |  | Balto. City  |  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN MUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR EMPLOYED   |  |
| Balto.  | 729 N. Kenwood Ave.  |  |  | House Cleaning   |  | Employed  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.   |  |  |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 13e. STREET ADDRESS  |  |   |  |
| John Schubert   |  | Frances Bishop   |  | 729 N. Kenwood Ave. #5   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT (NAME AND ADDRESS)   |  |   |  |
| no  |  | 212-32-0750A   |  | Mary Karwacki-Dght.<br>729 N. Kenwood Avenue 21205   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute CVA</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenoid Asceop</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u> <u>Hypertension</u>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Dr. Gracito Patricio</u> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>3/31/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |
| Dr. Gracito Patricio  |  |  |  | 2926 E. Cold Spring Lane   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial  |  | 4-3-81   |  | Oak Lawn Cemetery  |  | Balto., Md.   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Schimunek Funeral Home, Inc.<br>3331 Brehms Lane 21213  |  |  |  | APR 03 1981  |  | <u>[Signature]</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8106744   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>GEORGE P. BENSON   |  |  |  | March 30, 1981 6 Lg. M.  |  |   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>MAY 5, 1927  |  | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>53 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONTRACTOR  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONSTRUCTION   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN Pikesville   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>? ? ?  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>? ? ?   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO<br>WW II 120 16 1581   |  | 17. INFORMANT ADDRESS<br>Robert Collick, Riderwood, Maryland   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>pulmonary edema</u><br>(c) <u>intractable Cong. Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br><u>Pancreatic tumor - poorly differentiated</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>~5-10 mins</u><br><u>24 hrs</u><br><u>&gt; 4 wks</u> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Atrial Fibrillation</u>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>3/3/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Diagnosis of lung mass   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>March 2</u> , 19 <u>81</u> , to <u>March 30</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>March 30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>D. A. Kleinerman, MD</u> 9033  |  |  |  | DEGREE <u>MD</u>   |  | 22c. DATE SIGNED <u>3/30/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. A. Kleinerman, MD 9033   |  |  |  | 22e. ADDRESS<br>Sinai Hospital of Baltimore<br>Belvedere @ Greenspring Balto., MD 21215  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  | 23b. DATE<br>4/1/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Colonial Grove   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Virginia Beach, Va.  |  |
| 24 FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 02 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Collick</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled with information about the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| I. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | March 16 1981   |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | White  |  | Jan 12 1911   |  | 70   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Pa.  |  | USA  |  |   |  | Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Baltimore City Hospital  |  | Bakery  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. STREET ADDRESS  |  |
| Md.  |  |  |  | Balto.  |  | 243 S. Washington St.  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  |
| Martin Yurkiewicz  |  | Anna Kowalewski  |  | NO  |  | 216-16-6374  |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 F              |  |
| Shirley Sitko  |  | 7837 Kavanaugh Rd.   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus - Insulin |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-13 19 68, to 3-16-81, that (I) (we) last saw the deceased alive on 2-9 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |  |  |
| Theodore F. W. (illegible)   |  | DEGREE   |  | 3-18-81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  |
| T. T. NIZANIK (illegible)  |  | 429 S. Chester St. 21231   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | 3-19-81  |  | Sacred Heart of Jesus   |  | Balto. Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| John M. Weber & Sons Inc. 401 S. Chester St.   |  | MAR 18 1981  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |                  |  |   |
|---|------------------|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |                  | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                  | 2a. DATE OF DEATH  |   |
| FIRST MIDDLE LAST<br>Milford L. Berends   |                  | MONTH DAY YEAR<br>March 18, 1981   |   |
| 2b. HOUR<br>6:35 pm   |                  |  |   |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>4 <sup>TH</sup> 15 <sup>DAY</sup> 18 <sup>YEAR</sup>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |                  |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpet Mechanic   |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Rug Inst.   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |                  | 13b. COUNTY<br>Baltimore   |   |
| 13c. CITY OR TOWN<br>Baltimore  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 13e. STREET ADDRESS<br>719 S. Decker Avenue   |                  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick L. Berends  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Meyers   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII  |                  | 16b. SOCIAL SECURITY NO.<br>213-01-8504  |   |
| 16c. INFORMANT<br>Mrs. Phyllis Berends, 719 S. Decker Ave.<br>Baltimore, Md.  |                  | ADDRESS  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4/100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Atherosclerotic Cardiovascular Disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/22 hours |                  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |   |
| 19a. DATE OF OPERATION<br>March 18, 1981  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Peripheral vascular disease  |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                  |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from March 17, 1981, to March 18, 1981, that (1) (we) last saw the deceased on March 18, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death.   |                  |  |   |
| 22b. SIGNATURE<br>Anthony Tan, M.D.   |                  | 22c. DATE SIGNED<br>3/19/81  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anthony Tan, M.D.  |                  | 22e. ADDRESS<br>C/O Maryland General Hospital  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                  | 23b. DATE<br>3-21-81   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md.  |   |
| 24. FUNERAL DIRECTOR<br>Nicholas T. Matthews, 3021 Eastern Ave., Balto.   |                  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981   |   |

March 18, 1981      Derenda      Hildford

Baltimore City

Baltimore Maryland General Hospital

Myocardial Infarction

Atherosclerotic Cardiovascular Disease

March 18, 1981      Peripheral vascular disease

March 17      March 18      March 19

March 18      March 19      March 20

March 19      March 20      March 21

March 21      March 22      March 23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death must be expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8106747   |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY BERKEY</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 25, 1981</b>   |  |  |  | 2b. HOUR<br><b>10:30AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 12 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHN HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                                     |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3732 Gough Street</b>                                      |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vincent Zelachowski</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tillie Cichon</b>   |  |  |  | 21204  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Dorothy Hannahs, 915 Southwick D</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4151</b> IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>deep venous thrombosis</b>   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Severe rheumatoid arthritis causing invalid status</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>0</b>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>0</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/20</b> 19 <b>81</b> , to <b>3/25</b> 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>3/25</b> 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William R. Redwood MD</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/25/81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLIAM R. REDWOOD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>Town, Hopkins Hospital</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE<br><b>3/28/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Zannino Funeral Home, 263 S. Conkling</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy Hannahs</b>                                 |  |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #10a Film G554 4/1/81 re

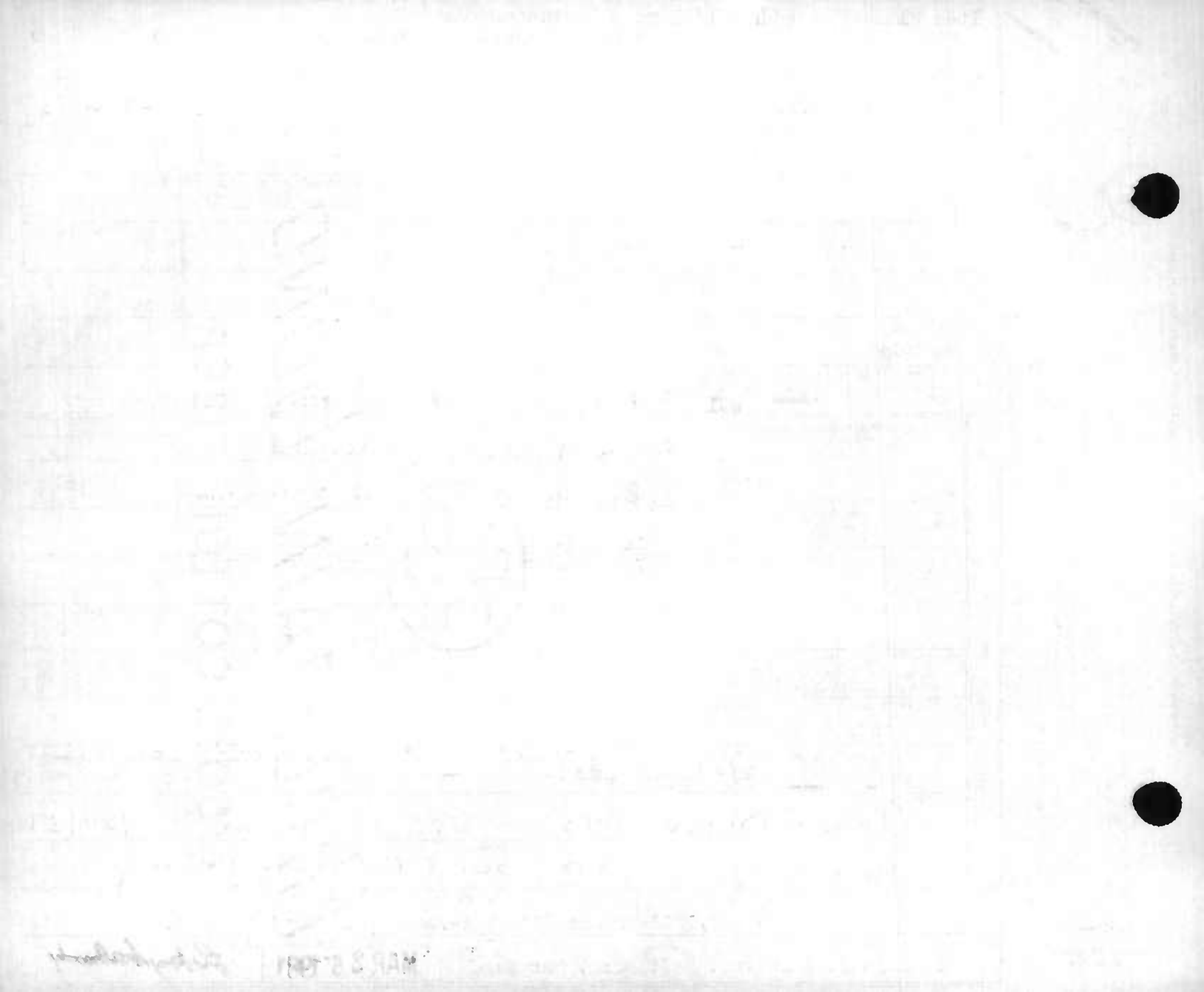
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 06748

1- FOR  
STATE  
REGISTRAR

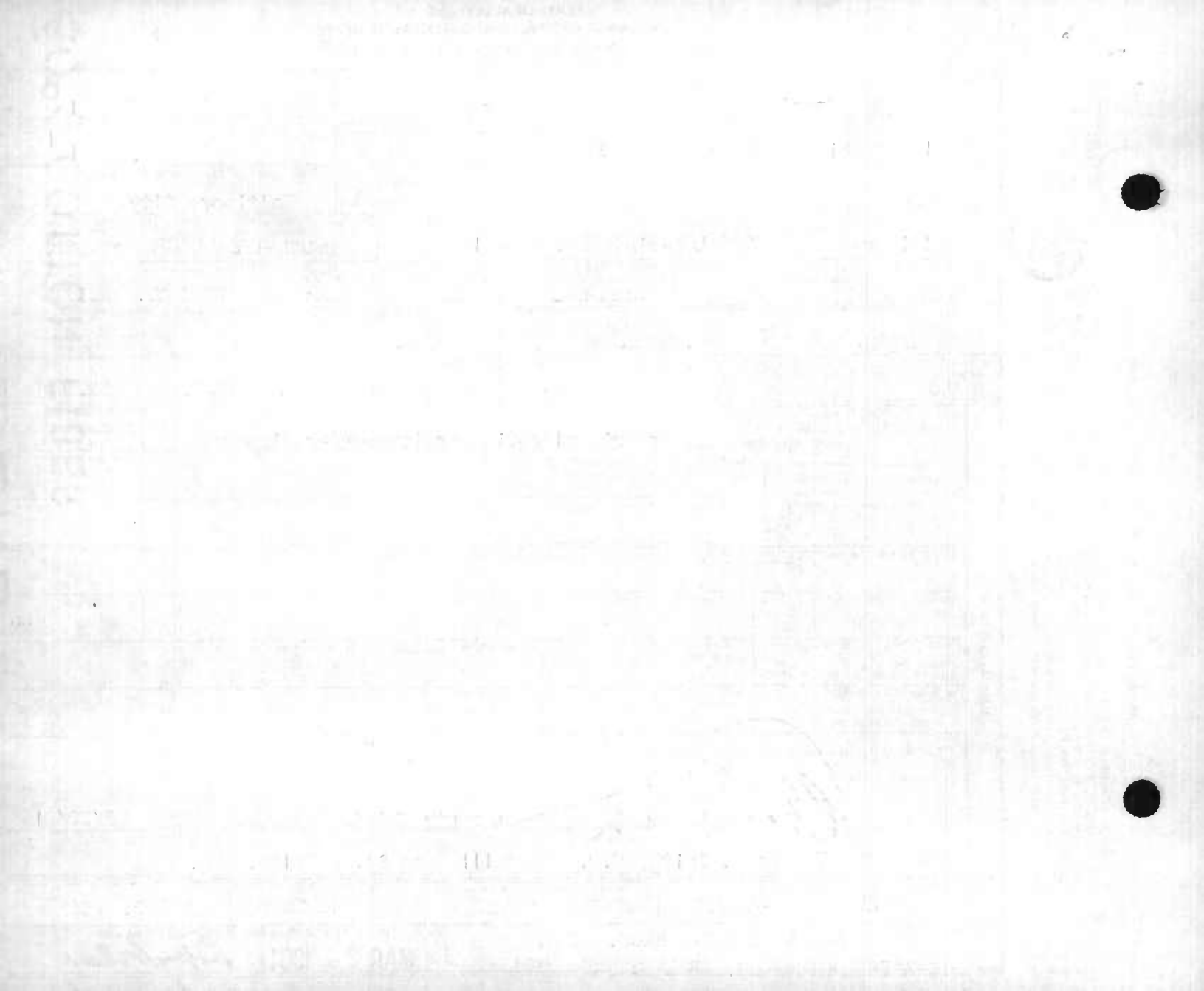
REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>UMBERTO M. BERLANDA</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 24 81</b> |   |  | 2b. HOUR<br><b>952 AM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 8, 1889</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bortolo Berlanda</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caterina Cogo</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 216-01-0381</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Catherine Frattali 3714 Meadowvale</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>possible Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Coronary artery Disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/24</b> , 19 <b>81</b> , to <b>3/24</b> , 19 <b>81</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>3/24</b> , 19 <b>81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>was</del> (did) <del>not</del> view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Ann E Duer, MD</b>  |  |   |   | DEGREE  |  | 22c. DATE SIGNED<br><b>3/24/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ann E Duer, MD</b>   |  |   |   | 22e. ADDRESS<br><b>201 E. University Pkway</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 27, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Veterans</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. Co. Md.</b>                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. Ruck</b>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |  |  |   |  | REG. NO. 06749  |  |  |  |                        |  |  |  |  |  |
|---|--|------------------|--|---|--|--|--|---|--|---|--|--|--|------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Bessie Berman   |  |                  |  |   |  |  |  |   |  | 2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3 22 19 81 |  | 2b. HOUR<br>M  |  |                        |  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>07 04 03   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.              |  | 7. IF UNDER 1 YR. MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>3 22 19 81   |  | 2d. HOUR<br>1:55A<br>M |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                  |  |                        |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4246 Labyrinth Rd. - on lawn |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |                        |  |  |  |  |  |
| 13a. STATE<br>MARYLAND  |  |                  |  | 13b. COUNTY<br>BALTIMORE  |  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                        |  | 13e. STREET ADDRESS<br>4246 LABYRINTH RD. #21215 |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>LOUIS EISENBERG  |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MOLLIE BUCHOFF  |  |  |  |   |  |   |  |  |  |                        |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>213-74-4423   |  |  |  | 17. INFORMANT ADDRESS<br>BENJAMIN BERMAN<br>4246 LABYRINTH RD. BALTO., MD 21215   |  |   |  |  |  |                        |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                       |  |                  |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                        |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |  |  |   |  |   |  |  |  |                        |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |                        |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                        |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                        |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above. I held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |   |  |  |  |                        |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>3/22/81   |  |                        |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |  |  |   |  |   |  |  |  |                        |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  | 23b. DATE<br>3/24/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SHOMREI HADATH |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD   |  |  |  |                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS., INC.   |  |                  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Brady</i>  |  |   |  |  |  |                        |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |                  |  |   |  |  |  |   |  |   |  |  |  |                        |  |  |  |  |  |

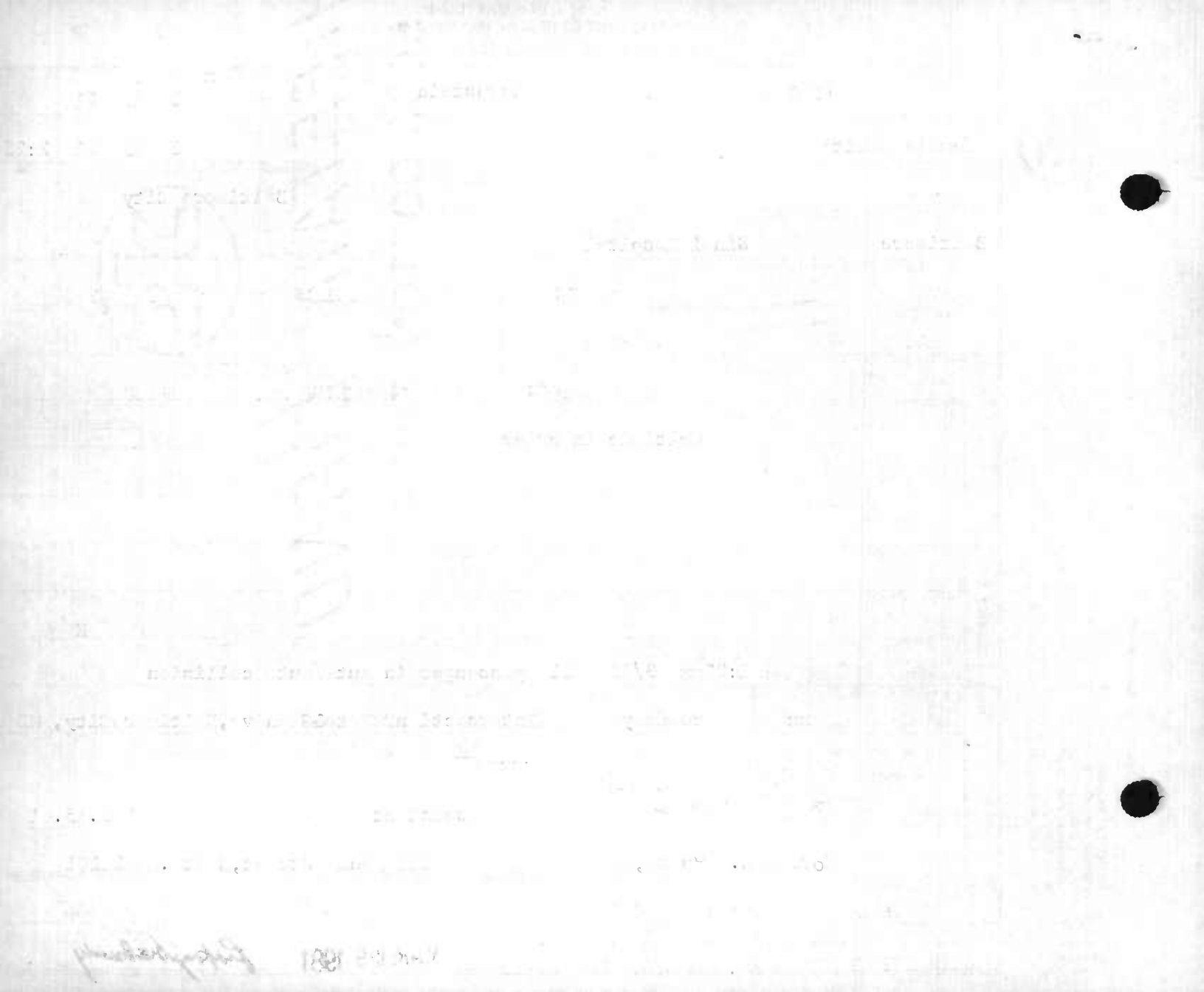


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 06750                                |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Sylvia  |  | MIDDLE<br>C.  |  | LAST<br>Bernstein   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                      |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 18, 1932   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>48 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 15 1981                             |  | 2d. HOUR<br>2:25 am                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2101 NORTHCLIFF DR.  |  | #21209  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MAX CLUSTER  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAMIE LOTT  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219-26-2484   |  | 17. INFORMANT<br>DR. SEYMOUR BERNSTEIN  |  | #21209  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>8/12/1<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:22xx 3/15 1981  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger in auto/auto collision   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Intersection Pk Hgts & Glen Ave, Baltimore City, MD  |  |   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>H. Shau</i>   |  | TITLE (SPECIFY)<br>M.D. Assistant  |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>3.15.81  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, MD  |  | ADDRESS<br>111 Penn Street, Balto, MD 21201  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/16/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMUNO  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony Brady</i>  |  |   |  |   |  |

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  | REG. NO.  |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | 2a. DATE OF DEATH  |   |  |   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES CARROLL BERRY   |  |   |  |  | MARCH 02 1981  |   |  |   |  | 5:33p M   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB 28 1945  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 74 HRS<br>HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3145 ELMORA AVENUE 21213 |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MIANTENANCE                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MD. YOUTH CTR.                       |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3145 ELMORA AVENUE 21213                           |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RAYMOND THEODORE BERRY  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORA ANNETTA POINTS          |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>219-42-5079   |  | 17. INFORMANT ADDRESS<br>FLORA BERRY 4 ST. PAUL AVE., REISTERSTOWN, MD.  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEIZURE DISORDER<br>7803<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21i. LOCATION<br>STREET  |   | CITY OR TOWN   |   | COUNTY STATE   |   |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from 01 NOVEMBER 1977 to 02 MARCH 1981, that (I) (X) lost<br>saw the deceased alive on 16 DECEMBER 1980, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (XX) (did not) view the body after death.                             |  |   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Arthur M. Lebson</i>   |  |   |  |  | DEGREE   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>02 MARCH 1980  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARTHUR M. LEBSON, M.D.   |  |   |  |  | 22e. ADDRESS<br>3640 FORDS LANE BALTO. 21215                                   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Mar. 6, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>piney grove cemetery                     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Boring, Balto.Co., Maryland |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H.G. Ehlhardt   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981                                    |   | 25b. REGISTRAR'S SIGNATURE<br>Owings Mills, Md.  |   |  |   |  |

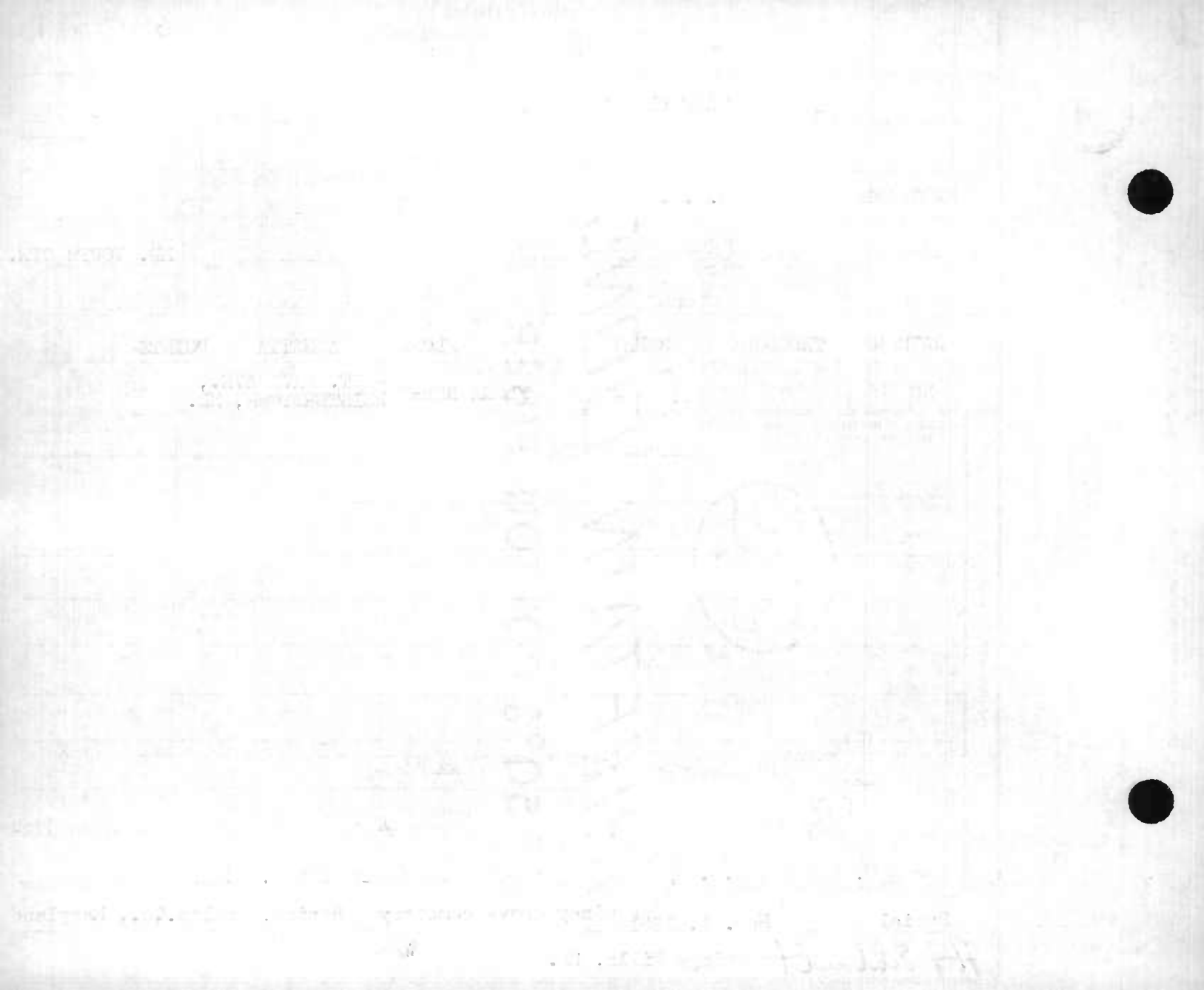
MEDICAL CERTIFICATION

29

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BP

0841



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 / 5 2

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>LEWIS JH BORTNER   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>3-25-81<br>2b HOUR<br>2:45 AM  |  |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7-9-24  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  | 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD                               |
| 10 CITY OR TOWN OF DEATH<br>BALTO.   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MD. HOSP. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECURITY GUARD. |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD.  |  | 13b COUNTY<br>BALTO.   | 13c CITY OR TOWN<br>BALTO.   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEWIS JH BORTNER  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LUCY H HERNDON   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II   |  | 16b SOCIAL SECURITY NO.<br>219-12-6250   |  |
| 17 INFORMANT<br>Mrs. Margaret Bortner  |  | ADDRESS<br>1111 Roland Heights   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) POST OPERATIVE MYOCARDIAL<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) INFARCTION WITH HEART<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) FAILURE.<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |
| 19a DATE OF OPERATION<br>3-23-81   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CORONARY ARTERY DISEASE   |  |
| 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d INJURY OCCURRED<br>21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21g DATE SIGNED  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 3/20/81 to 3/25/81, that (I) (we) lost saw the deceased alive on 3/25/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  | 22b SIGNATURE<br>Sohaila Aziz, M.D.  |  |
| 22c PHYSICIAN'S NAME (TYPE OR PRINT)<br>SOHAILA AZI, M.D.  |  | 22d ADDRESS<br>UNIV. OF MD. HOSPITAL.  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br>3/28/81  |  |
| 23c NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave.  |  | 25 REG. BY REGISTRAR<br>25 REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

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A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave.

Initial

3/25/81

Trans Right Com.

Baltimore

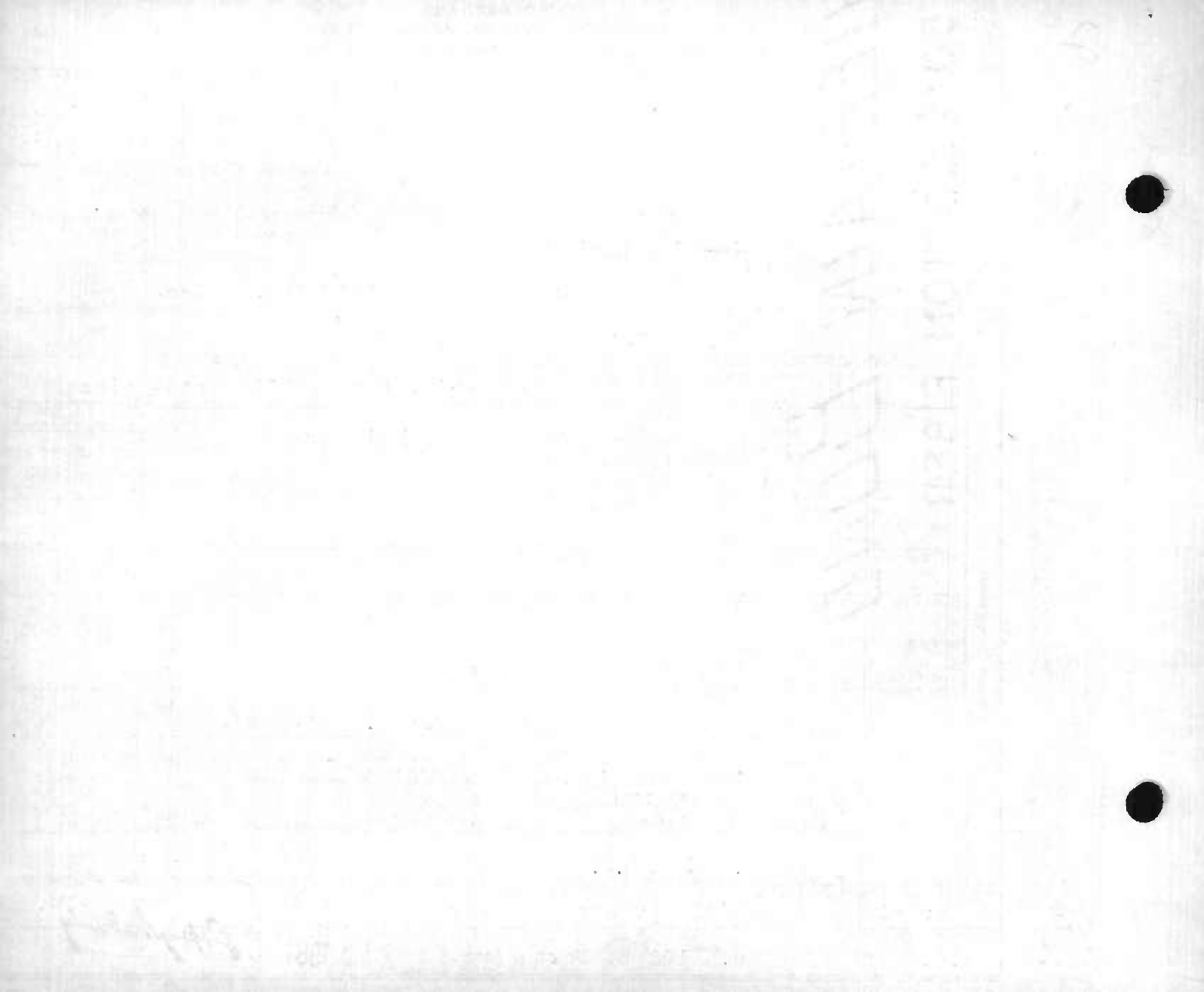
No.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PAVAN STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2 BP 2  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

| <div style="display: flex; justify-content: space-between;"> <span>FOR<br/>STATE<br/>REGISTRAR</span> <span> <b>STATE OF MARYLAND</b><br/> <b>DEPARTMENT OF HEALTH AND MENTAL HYGIENE</b><br/> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </span> <span>1 0 6 7 5 3</span> </div> |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <span style="float: right;">REG. NO.</span>   |  |   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| James E. Bethea   |  |   |  |   |  | <div style="display: flex; align-items: center;"> <input checked="" type="checkbox"/> KNOWN<br/> <input type="checkbox"/> ESTI-MATED </div> |  | <div style="display: flex; align-items: center;"> <div>MONTH DAY YEAR</div> <div>3 10 81</div> </div>        |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | 7. BIRTHPLACE  |  |
| Male  |  | Black   |  | <div style="display: flex; align-items: center;"> <div>MONTH DAY YEAR</div> <div>12 3 41</div> </div> |  | <div style="display: flex; align-items: center;"> <div>MONTHS DAYS HOURS MINS</div> <div>39 YRS.</div> </div>                               |  | <div style="display: flex; align-items: center;"> <div>STATE OR FOREIGN COUNTRY</div> <div>S.C.</div> </div> |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                                  |  | 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS   |  | 13. STREET ADDRESS   |  |
| Baltimore   |  | University Hospital   |  | FOR MOST OF WORKING LIFE  |  | OR INDUSTRY   |  | 1318 Eutaw Place   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. SOCIAL SECURITY NO.  |  | 16b. DATE OF OPERATION  |  | 16c. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| Lorne   |  | Hessie  |  | 146-34-2365   |  | <div style="display: flex; align-items: center;"> <div>DATE</div> <div>3/16/81</div> </div>   |  | <div style="display: flex; align-items: center;"> <div>CONDITION</div> <div>Church Cemetery</div> </div>     |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH  |  | 19. DATE OF OPERATION   |  | 20. AUTOPSY?  |  | 21. TIME OF INJURY   |  |
| Louise Bethea   |  | <div style="display: flex; align-items: center;"> <div>CAUSE</div> <div>8820</div> </div> |  | <div style="display: flex; align-items: center;"> <div>DATE</div> <div>3/10/81</div> </div>           |  | <div style="display: flex; align-items: center;"> <div>CONDITION</div> <div>Subject fell from 2nd floor window</div> </div>                 |  | <div style="display: flex; align-items: center;"> <div>TIME</div> <div>3 9 19 81</div> </div>                |  |
| 22. I certify that I took charge of the remains described above, held on  |  | 23. NAME OF CEMETERY OR CREMATORY   |  | 24. FUNERAL DIRECTOR  |  | 25. DATE REC'D. BY REGISTRAR  |  | 26. SIGNATURE  |  |
| <div style="display: flex; align-items: center;"> <div>NAME</div> <div>Thomas D. Smith, M.D.</div> </div>   |  | Church Cemetery   |  | WM.C.MARCH F/H INC.   |  | MAR 13 1981   |  | <div style="display: flex; align-items: center;"> <div>SIGNATURE</div> <div> </div> </div>                   |  |

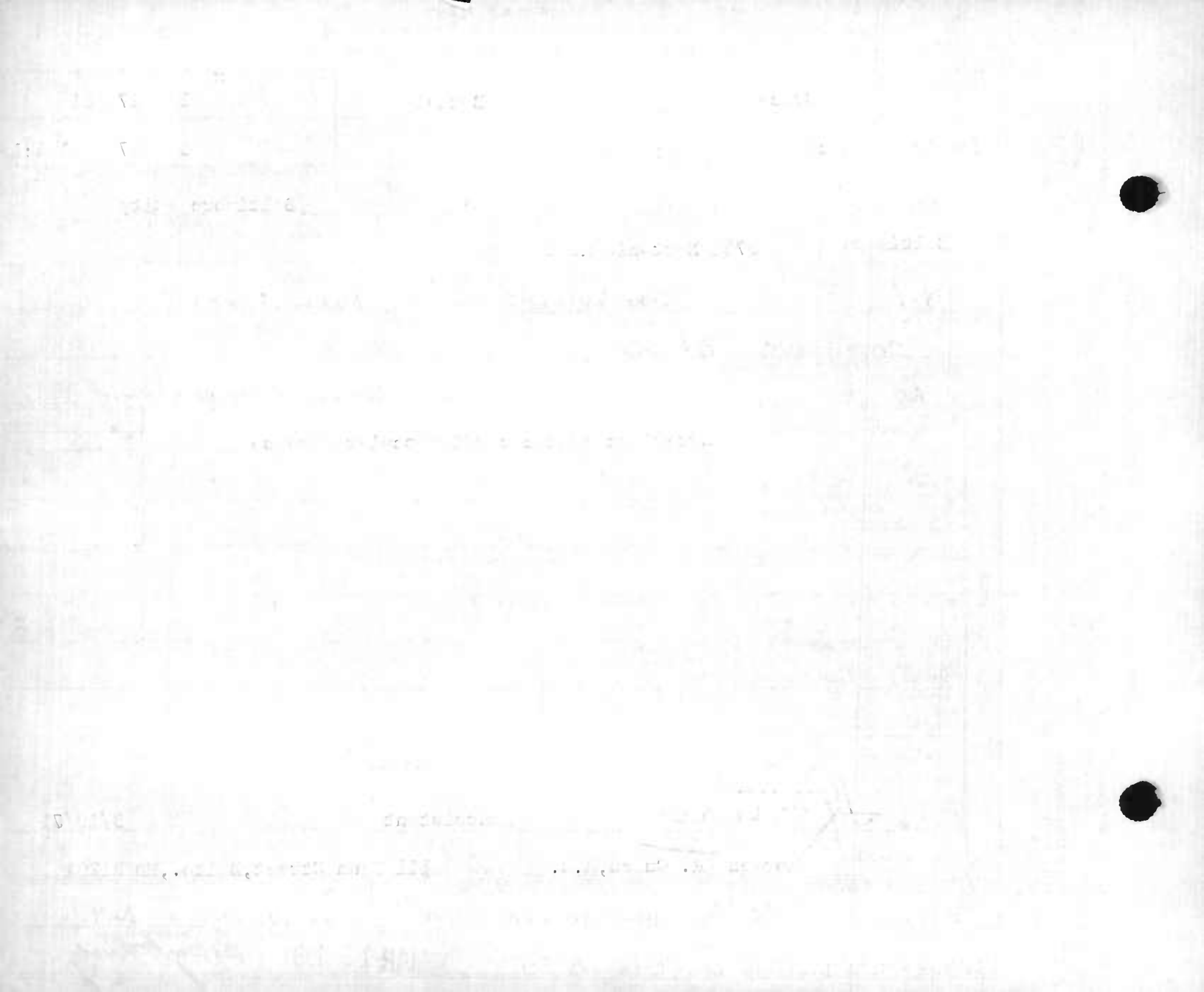


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VRA15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |  | REG. NO. 06754  |  |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Grace C. Bethal</b>  |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 17 81</b> |  |
| 3. SEX <b>female</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5-10-98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82 YRS.</b>   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>3 17 81 4:19 PM</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>                            |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3741 Nortonia Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>N.Y.</b>   |  |                      |  | 13b. COUNTY <b>LAKE LUZERNE</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>MILL STREET</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>CORNELIUS BRIGGS</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOUELLA</b>                                    |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS <b>SYLVIA HENRY 3741 Nortonia Rd.</b>                                  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                      |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |  |                      |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | DATE SIGNED <b>3/18/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>3/21/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LAKE LUZERNE CEM.</b>                                  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAKE LUZERNE, N.Y.</b>                         |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>VERNON BAILEY 1348 N. CALHOUN ST.</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate should be retained by the hospital or attending physician. It should be detached for use as the burial permit permit. Then please remove carbon pages. Page 1 of this should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH: 16 30M 2/80  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 5 5

| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DELORES M. BETTERS</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 13, 1981</b>   |  |
| 3 SEX<br><b>F</b>  |  | 2b. HOUR<br><b>4:28AM</b>   |  |
| 4 RACE<br><b>B</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 23 40</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br><b>1222 Ensor St.</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry A. Goldston</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sarah Matthews</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-9683</b>  |  |
| 17. INFORMANT ADDRESS<br><b>Mark A. Strange 1731 Terrell Pl.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>hypertension</b>  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET   |  | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>81</b> , to <b>3/13</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |
| 22b. SIGNATURE<br><b>Mark J. Ratain</b>  |  | DEGREE<br><b>M.D.</b>   |  |
| 22c. DATE SIGNED<br><b>3/13/81</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK J. RATAIN</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/18/81</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville, Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>   |  |
| ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. [Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 / 5 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>ERNEST R. BIBEAU</b>   |  |   |  | MONTH DAY YEAR HOUR<br><b>MARCH 18, 1981</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb 6, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>77</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Home = 107 W. Jeffrey Street</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clothing</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bibeau</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma</b>  |  | 13e. STREET ADDRESS<br><b>107 W. Jeffrey Street</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>037 01 5378</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Ernest Bibeau same as 13 e</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>2500 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Ischemic Cardiovascular Disease</b><br>(c) <b>Diabetes</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/6/81</b> , 19 <b>81</b> , to <b>3/18</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/18</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Surya P Mundra</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/20/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURYA P MUNDRA</b>   |  | 22e. ADDRESS<br><b>203E Patapsco Ave Balt MD 21225</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/20/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>   |  |   |  | ADDRESS<br><b>4001 Ritchie Hgwy Balto 21225</b>   |  | 25a. DAY RECEIVED BY REGISTRAR<br><b>MAR 24 1981</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 7 5 7  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Henry J. B. Lemiller</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03 22 81</b>  |  | 2b. HOUR<br><b>1:30 PM</b>   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 17 1963</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>17</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.)<br><b>Bookkeeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cleveland</b>  |  |
| 13a. STATE<br><b>md.</b>   |  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Henry</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Baker</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-10-8624</b>   |  | 17. INFORMANT ADDRESS<br><b>Berth M. Will 6001 Eastern Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE RESPIRATORY FAILURE</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD- PROBABLY ca OF THE LUNG C CAVITATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-17</b> , 19 <b>81</b> , to <b>3-22</b> , 19 <b>81</b> , that (I) (we) lost <b>some</b> the deceased alive on <b>3-22</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Walter Impagliatelli</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>81 3-22-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER, IMPAGLIATELLI</b>  |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSP. CORP. 100 N. BROADWAY</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-24-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore City md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Thelma Hoffman</b>   |  |  |  | 24b. ADDRESS<br><b>3218 Hudson St.</b>   |  |  |  |
| 25. NOTED BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Walter J. O. [Signature]</b>  |  |  |  |

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 8 1 0 6 7 5 8  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ESTHER A BLEINBERGER</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 31 81</b>  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 26 1909</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72 7/71</b> YRS.  |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hospital</b> |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore City</b>  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph NXXXXXX Smith</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NOT UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>XXXXXX</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>255-03-9302</b>  |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Robert Bleinberger Same 704 N. Belmord</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>XXXXXX</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia with septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 29 19 81</b> to <b>March 31 19 81</b> , that (I) (we) lost saw the deceased alive on <b>March 31 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Susan Voss, MD</b> DEGREE  |  |  |   | 22c. DATE SIGNED<br><b>3/31/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUSAN VOSS, MD</b>  |  |  |   | 22e. ADDRESS<br><b>3001 S. HANOVER ST. Baltimore, Md</b>                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/6/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1981</b>                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |  |  |





APR 2 1981

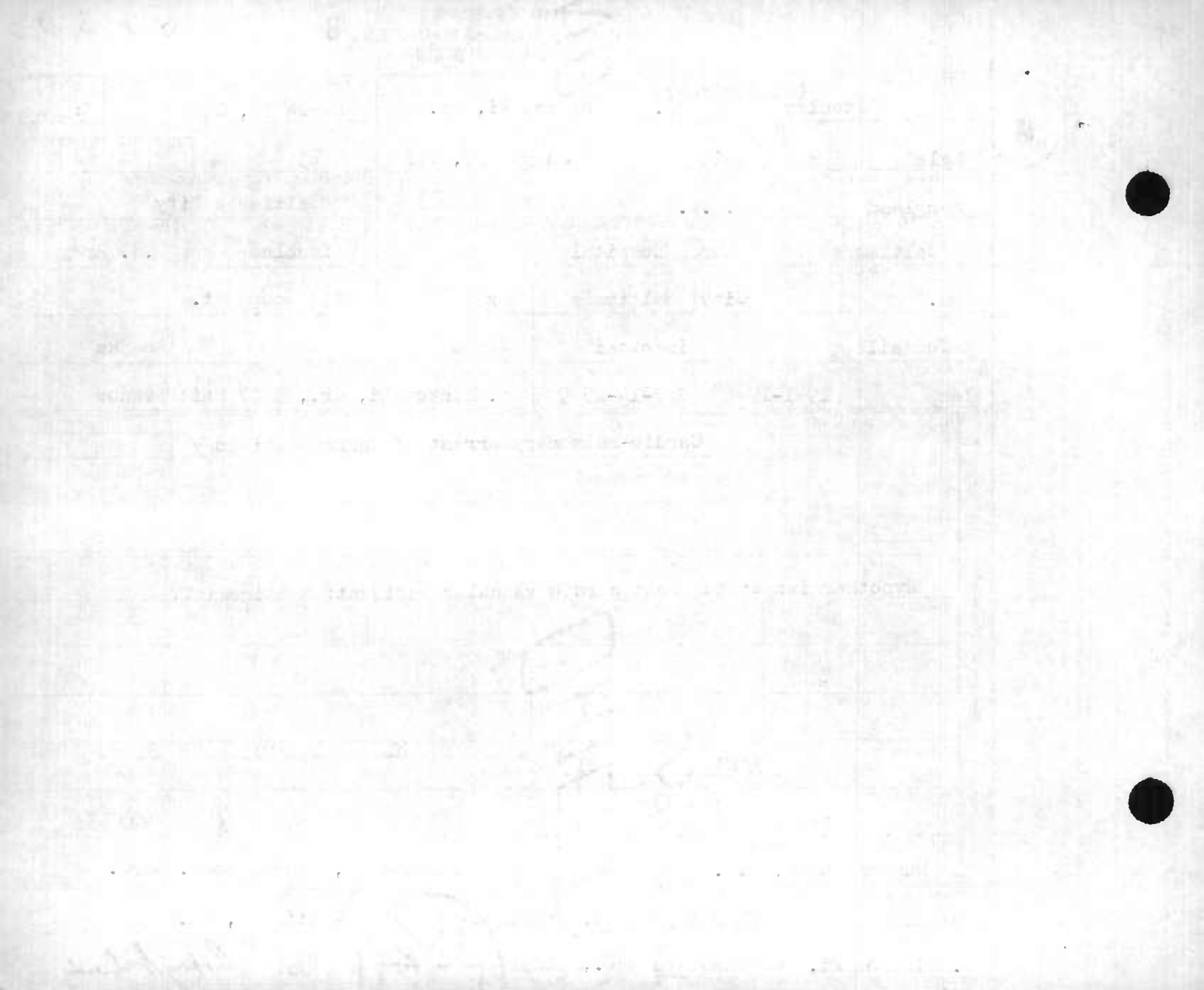


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 06759                               |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> (Stanislaus) <sup>MIDDLE</sup> Stanley <sup>LAST</sup> Binkowski, Sr. |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR March 10, 1981                        |  | 2b. HOUR 3:50A M   |  |  |  |
| 3. SEX Male  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR July 20, 1916   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS                                 |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 7. IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled |  | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Army  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.  |  |   |  | 13b. COUNTY City  |  | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 1813 Gough St.           |  |
| 14. FATHER'S NAME <sup>FIRST</sup> Teofil <sup>MIDDLE</sup> <sup>LAST</sup> Binkowski  |  |   |  | 15. MOTHER'S MAIDEN NAME <sup>FIRST</sup> Agnes <sup>MIDDLE</sup> <sup>LAST</sup> Majka   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | 16b. SOCIAL SECURITY NO. 1941-1946  |  | 17. INFORMANT S. Binkowski, Jr.,  |  | ADDRESS 3817 Fait Avenue   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY: <b>4275</b> IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest of Unknown Etiology<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypothermia: Status Post cardio vascular accident: septicemia??   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET  |  | CITY OR TOWN   |  | COUNTY   |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10, 19 81, to 3/10, 19 81, that (I) (we) lost saw the deceased alive on 3/10, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Mukesh Luhar</i>   |  |   |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 4/5/81                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mukesh Luhar, M.D.   |  |   |  | 22e. ADDRESS 100 N. Broadway, Church Hosp. Corp.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 3/13/81   |  | 23c. NAME OF CEMETERY OR CREMATORY St. Stanilaus  |  | 23d. LOCATION CITY OR TOWN Baltimore, Md.                              |  | COUNTY   |  | STATE  |  |
| 24. FUNERAL DIRECTOR NAME W. Fialkowski, 2007 Eastern Ave., 21231  |  |   |  | 25a. DATE REC'D. BY REGISTRAR APR 8 1981  |  | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>                      |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |                                  |   |  |  |                 |  | REG. NO.                                      |                                  |
|---|--|--|--|----------------------------------|---|--|--|-----------------|--|---|----------------------------------|
| 1. FOR STATE REGISTRAR  |  |  |  |                                  | 2a. DATE OF DEATH                                 |  |  |                 |  | 2b. HOUR                                      |                                  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>RAE — BISHOW</b>  |  |  |  |                                  | MONTH DAY YEAR <b>03 10 81</b>                    |  |  |                 |  | 7 <sup>15</sup> P <sup>M</sup>                |                                  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUCASION</b>   |  | 5. DATE OF BIRTH                 |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS                               |                                  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | MONTH DAY YEAR <b>03 10 1902</b> |   | 79 YRS. — —  |  | MONTHS DAYS     |  | HOURS MIN.                                    |                                  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |                                  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>                     |  |                 | MD.  |   |                                  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>  |  |  |  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY <b>MEDICINE</b> |  |  |                 |  |   |                                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |                                  | 13b. CITY OR TOWN                                 |  |  |                 |  | 13c. INSIDE CITY LIMITS?                      |                                  |
| 13a. STATE <b>MD</b>  |  |  |  |                                  | 13b. COUNTY <b>—</b>                              |  |  |                 |  | 13c. CITY OR TOWN <b>BALTIMORE</b>            |                                  |
| 14. FATHER'S NAME   |  |  |  |                                  | 15. MOTHER'S MAIDEN NAME                          |  |  |                 |  |   |                                  |
| FIRST MIDDLE LAST <b>JOSEPH — BISHOW</b>  |  |  |  |                                  | FIRST MIDDLE LAST <b>JENNIE — PETRASHONSKY</b>    |  |  |                 |  |   |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |                                  | 16b. SOCIAL SECURITY NO. <b>218-30-5285</b>       |  |  |                 |  | 17. INFORMANT <b>MYRON BISHOW</b>             |                                  |
| IF YES, GIVE WAR OR DATES   |  |  |  |                                  | APT. <b>A</b>                                     |  |  |                 |  | ADDRESS <b>6430 ELRAY DR. BALTO, MD 21209</b> |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |                                  |   |  |  |                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b>  |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| 5789 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastrointestinal bleed.</b>   |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>   |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>—</b>   |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |                                  |   | 20a. AUTOPSY?  |  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |   |                                  |
| —   |  |  | —  |                                  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY                              |                                  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |                 |  |   |                                  |
| —   |  |  | HOUR A.M. MONTH DAY YEAR                         |                                  |   | —  |  |                 |  |   |                                  |
| —   |  |  | P.M. 19  |                                  |   | —  |  |                 |  |   |                                  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY                             |                                  |   | 21f. LOCATION  |  |                 |  |   |                                  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                  |   | STREET   |  |                 | CITY OR TOWN COUNTY STATE  |   |                                  |
| —   |  |  | —  |                                  |   | —  |  |                 | —  |   |                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/10/81</b> , to <b>03/10/81</b> , that (I) (we) lost saw the deceased alive on <b>03/10/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| 22b. SIGNATURE <b>Mrd. R. Shar.</b>   |  |  |  |                                  |   |  |  |                 | DEGREE <b>M.D.</b>   |   | 22c. DATE SIGNED <b>03/10/81</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MOHAMMED R. SHAREEF</b>  |  |  |  |                                  |   |  |  |                 | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                                  |
| 22e. ADDRESS <b>SINAI HOSPITAL BALTIMORE, MD.</b>   |  |  |  |                                  |   |  |  |                 |  |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE <b>3/13/81</b>                         |                                  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>                         |  |                 | 23d. LOCATION  |   |                                  |
| —   |  |  | —  |                                  |   | —  |  |                 | CITY OR TOWN COUNTY STATE  |   |                                  |
| —   |  |  | —  |                                  |   | —  |  |                 | BALTIMORE MARYLAND   |   |                                  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  |                                  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1981</b>                               |  |                 | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |                                  |
| NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |                                  |   |  |  |                 |  |   |                                  |

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PAR. 1



1961 MAY 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 7/77  
(VR 4 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 6 1

|  |   |   |   |
|--|---|---|---|
| FOR<br>1. STATE<br>REGISTRAR   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH MONTH DAY YEAR  |   |
| FIRST MIDDLE LAST<br><b>LOUIS JOHN BITTNER</b>   |   | <b>March 24, 1981</b>   |   |
| 2b. HOUR   |   | <b>7:30 AM</b>  |   |
| 1. SEX   | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)   |
| <b>Male</b>  | <b>White</b>  | <b>July 14, 1905</b>  | <b>75</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |
| <b>Balto. Md.</b>  | <b>U.S.A.</b>   |   | <b>Baltimore City</b> MD.   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| <b>Baltimore</b>   | <b>3222 Fait Avenue</b>   | <b>Retired</b>  | <b>Brewery</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |
| 13a. STATE   | 13b. COUNTY   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | <b>3222 Fait Avenue</b>   |
| <b>Md.</b>   | <b>Baltimore</b>  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |
| <b>Conrad Bittner</b>  | <b>Mary C. Ruley</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS   |   |
| <b>No</b>  | <b>215-03-4370</b>  | <b>Barbara A. Bittner 3222 Fait Avenue</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?              |
|  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/31/78</b> , 19 <b>81</b> , to <b>3/24</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/16/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                           |   |   |   |
| 22b. SIGNATURE<br><b>David Mishkin</b>   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       | 22c. DATE SIGNED<br><b>3/24/81</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Mishkin</b>  | 22e. ADDRESS<br><b>Balto City Hospitals</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>3-27-81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. County Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son 901 S. Conkling St.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>                        |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |   |
|--|--|--|--|---|---|--|---|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.  |  |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM David BLACK SR.</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>9</b> YEAR <b>81</b> |  |   |  |   |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>22</b> YEAR <b>1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |   | 7b. HOUR<br><b>9:19P M</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>  |   |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>911 Southerly Road</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>MILTON</b> MIDDLE <b>BLACK</b> LAST <b>BLACK</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EDITH</b> MIDDLE <b>Mc</b> LAST <b>KENNY</b>   |   |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Mrs. Esther L. Black</b>  |   | ADDRESS<br><b>Same</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>2000</b> <i>pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>diffuse histiocytosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>lymphoma</i>  |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b><br><b>4 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |   |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |
| 22a. I certify that <b>20</b> (this hospital) attended the deceased from <b>MARCH 2,</b> 19 <b>81</b> , to <b>MARCH 9,</b> 19 <b>81</b> , that <b>X</b> (we) last saw the deceased alive on <b>MARCH 9,</b> 19 <b>81</b> , and that in <b>X</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>20</b> (we) did <b>not</b> see the body after death. |  |  |  |   |   |  |   |  |   |
| 22b. SIGNATURE<br><i>[Signature]</i><br>PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CONDRO, P.</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/10/81</b>   |   |
| 22d. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>   |  |  |  |   |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/12/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto. Co., Md.</b> COUNTY STATE |  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>  |  |  |  |   |   | DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>   |   | 25. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |

BP

Corporation Civil  
Services

Tolson

8/12/64

3900 Loch Avenue, N.W., Wash., D.C. 20007

1900 York Road, Baltimore, Md. 21212  
Henry W. Jenkins & Sons Co.  
Baltimore, Md. 21212  
Baltimore, Md. 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 6 7 6 4  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |  |  |
| LENORA R. BLADES  |  |   |  | 3 24 81 4P M   |  |  |  |
| 3 SEX<br>F  |  | 4 RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT. 21, 1896  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CTY. MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>MIDDLE RIVER  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1737 GLEN CURTIS RD. - 21221 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>MIDDLE RIVER  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES N. STERLING   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA MEREDITH  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-09-1007  |  | 17. INFORMANT<br>CHARLES BLADES -  |  | ADDRESS<br>712 WAMPLER RD.<br>BALTO. 21220   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PERICARDIAC THROMBOSIS</u><br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GENERALIZED ARTERIO SCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHRONIC</u>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 WEEKS  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a-   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1979</u> , 19 <u>81</u> , to <u>MARCH 24</u> , 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>3/24</u> , 19 <u>81</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J. DAVID MAGR   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED<br>3-26-81  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3-27-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SUNNYRIDGE CEMETERY  |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>CRISFIELD - SOMERSET - MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BRADSHAW + SONS -   |  | ADDRESS<br>21817 CRISFIELD, MD.   |  | DATE RECEIVED BY REGISTRAR<br>MAR 30 1981  |  |  |  |



STATE OF

1874

MARYLAND

MIDDLE RIVER BRIDGE, GREEN CREEK, DISTRICT OF COLUMBIA, D.C.  
MAY 1874

CHARLES M. STEVENS  
1100-101 CHAMBERS STREET  
NEW YORK

ESTIMATES  
FOR THE

REPAIRS

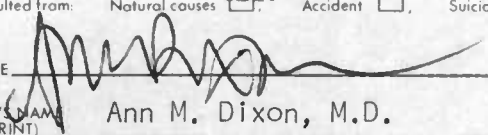
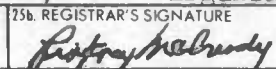
ON

THE

BRIDGE

FOR THE YEAR 1874

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITHIN 24 HOURS, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITHIN 24 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |                                  |  |  |  |  |  |  | REG. NO. 06765   |  |
|--|----------------------|--|----------------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>LLOYD Denver BLAKE</b>   |                      |  |                                  |  |  |  |  |  |  | 2a. DATE OF DEATH <input checked="" type="checkbox"/> KNOWN <input type="checkbox"/> ESTIMATED <b>3 28 19 81</b> |  |
| 3. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH <b>July 23, 1927</b>  | 6. AGE (IN YEARS) <b>53</b> YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD <b>3 28 19 81</b>   |  | 2d. HOUR <b>7:20</b> P M   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital (DOA)</b> |                                  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>                                |  |  |  |
| 13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                      |  |                                  |  |  |  |  |  |  | 13d. STREET ADDRESS <b>7420 Poplar Avenue 21224</b>  |  |
| 14. FATHER'S NAME <b>Roy</b> MIDDLE <b>-</b> LAST <b>Blake, Sr.</b>  |                      |  |                                  | 15. MOTHER'S MAIDEN NAME <b>Letha</b> MIDDLE <b>-</b> LAST <b>McCauley</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |                      | 16b. SOCIAL SECURITY NO. <b>235-40-2940</b>  |                                  | 17. INFORMANT <b>Nadean Blake, Wife</b>  |  | 17. ADDRESS <b>Same</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                      |  |                                  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |                      |  |                                  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                      |  |                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |  |                                  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE    |                      |  |                                  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>3-29-81</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      |  |                                  | ADDRESS <b>111 Penn St.</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>4-2-81</b>  |                                  | 23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN <b>Burnsville, West Virginia</b> COUNTY STATE   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Brazdzinski Funeral Home</b>   |                      |  |                                  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |



x

1967, 1968

1967, 1968

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*[Handwritten signature]*

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Item Pt. 2 G554  
4/24/81 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06166

|  |         |  |                       |  |  |
|--|---------|--|-----------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | 2a. DATE KNOWN OF DEATH  |                       | 2b. HOUR   |  |
| Carlton Jay Blanchard  |         | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 3 1981  |                       | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)     | IF UNDER 24 HRS.   |  |
| Male   | Black   | 12 9 80  | YRS. 2 MONTHS 22 DAYS | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| Maryland   |         | U.S.A.   |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore  |         | Sinai Hospital   |                       | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore  |         | Sinai Hospital   |                       | None   |  |
| 13a. STATE   |         | 13b. COUNTY  |                       | 13c. CITY OR TOWN  |  |
| MD.  |         | Baltimore  |                       | Baltimore  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                       | 16. SOCIAL SECURITY NO.  |  |
| James  |         | Wendy  |                       | 17. INFORMANT  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |                       | 17. INFORMANT  |  |
| NO   |         | 16b. SOCIAL SECURITY NO.   |                       | 17. INFORMANT  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I DEATH WAS CAUSED BY:  |         | PART I DEATH WAS CAUSED BY:  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 8769 IMMEDIATE CAUSE (a) Hypoxic encephalopathy  |         | 8769 IMMEDIATE CAUSE (a) Hypoxic encephalopathy  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         | DUE TO, OR AS A CONSEQUENCE OF   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| (b) Intra-operative cardiac arrhythmia & respiratory arrest  |         | (b) Intra-operative cardiac arrhythmia & respiratory arrest  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| (c)  |         | (c)  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                       | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |
| Idiopathic hypertrophy of the left   |         | Idiopathic hypertrophy of the left   |                       | Idiopathic hypertrophy of the left   |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                       | 20. AUTOPSY?   |  |
| 2/24/81  |         | Inguinal hernia  |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |
| ?  |         | HOUR A.M. MONTH DAY YEAR ? P.M. 3/3/81   |                       | Therapeutic misadventure   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                       | 21f. LOCATION  |  |
| Hospital   |         | Hospital   |                       | Sinai Hospital, Baltimore City, Md.  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |         | 22a. I certify that I took charge of the remains described above, held on death resulted from:   |                       | 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                       | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |                       | DATE SIGNED  |  |
| Virginia L. Dolan  |         | M.D. Assistant   |                       | 3/3/81   |  |
| EXAMINER'S NAME  |         | ADDRESS  |                       | ADDRESS  |  |
| Virginia L. Dolan, M.D.  |         | 111 Penn Street, Baltimore, MD. 21201  |                       | 111 Penn Street, Baltimore, MD. 21201  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         | 23b. DATE  |                       | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |         | 3/5/81   |                       | MD. NAT'L PARK   |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |                       | 25b. REGISTRAR'S SIGNATURE   |  |
| Chas. H. Powell  |         | MAR 10 1981  |                       | MAR 10 1981  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1513 BP  
DHMH-17  
(VR A15 ME (3))  
15M 2/80



Department of the Interior  
Bureau of Land Management  
Washington, D. C. 20240



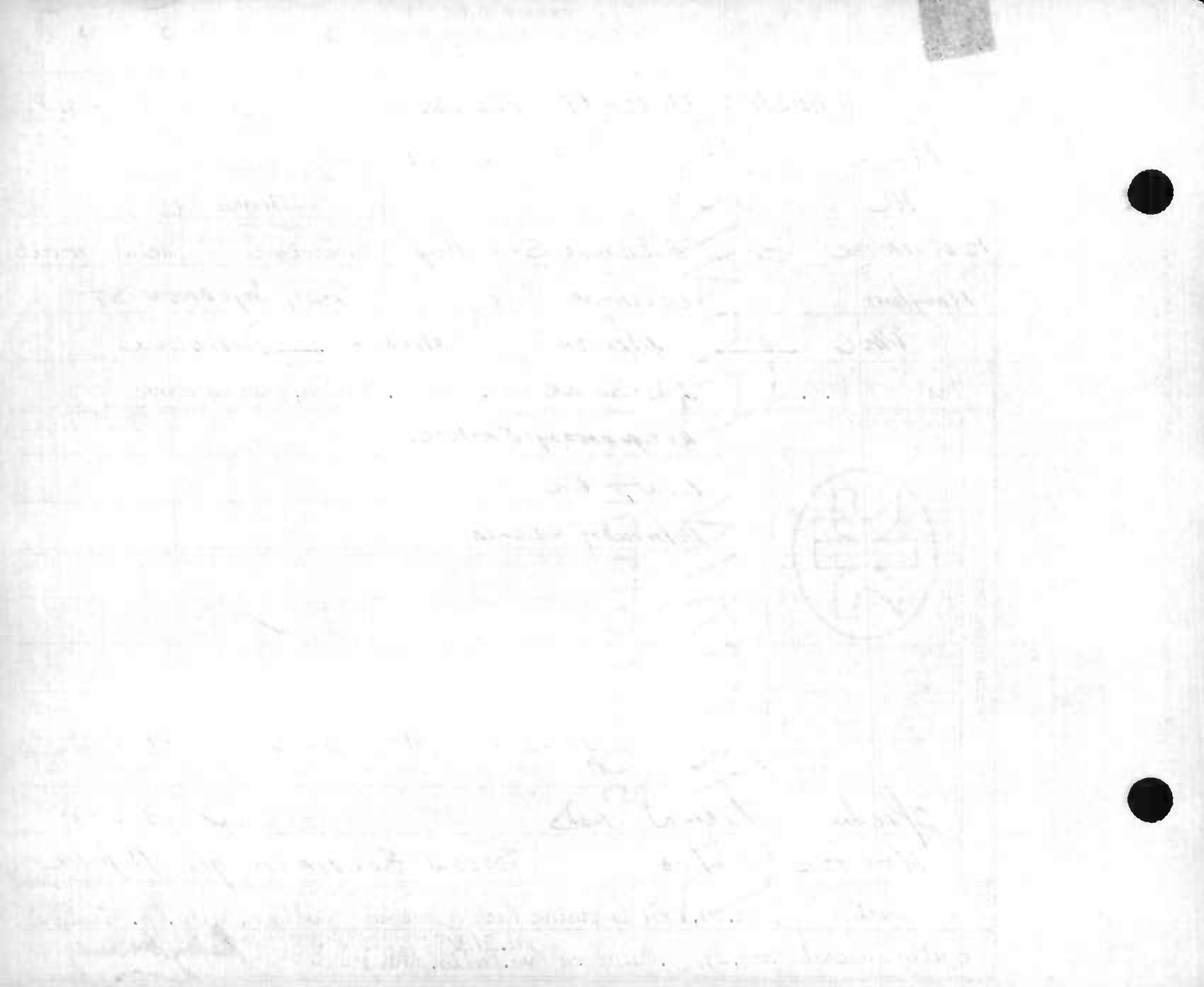
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 8106161   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES CULLETT BLANTON SR.</b>   |  |  |  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
|  |  |  |  |  |  | 3 6 81   |  |  |  | 7:25 PM  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 30 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen. Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Security</b>                          |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>  |  |  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>1509 Sycamore St</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PAUL L BLANTON</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HENRIE DEERING</b>                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>Yes</b>  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF N.W., GIVE YEAR OR DATES)<br><b>W.W. 2 345-32-7026</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Helen L. Blanton, Same as above</b>              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LUNG Ca</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PULMONARY EDEMA</b> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-23-81</b> , 19 <b>81</b> , to <b>3-6</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                            |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Hector Silva</b> MD   |  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>3-6-81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HECTOR SILVA</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>SOUTH BALTIMORE Gen. Hosp. bldg</b>                                 |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  |  | 23b. DATE<br><b>Mar. 10, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto. Co. Maryland</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>McQuay Funeral Home, 237 E. Patapsco</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>Md. 21225 MAR 12 1981</b>                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur J. Kennedy</b>                               |  |  |  |



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 1 0 6 / 6 8

 FOR  
 STATE  
 REGISTRAR

REG. NO.

|  |  |  |  |   |   |   |  |
|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE EDWARD BLUME</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>30</b> YEAR <b>81</b> |   |   | 2b. HOUR<br><b>9:29<sup>P</sup></b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>22</b> YEAR <b>98</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC Baltimore, Maryland 21218</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sanitation</b>           |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>?</b> MIDDLE LAST <b>Blume</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Unknown</b>   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)<br><b>WW I</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 22 8057</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr George W Blume 3518 Rosekemp Ave</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia - Bilateral</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br><b>4860</b>   |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 24</b> , 19 <b>81</b> , to <b>March 30</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 30</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Kristen B. Raines MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/31/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kristen Raines</b>   |  |  |  | 22e. ADDRESS<br><b>VAMC, Baltimore, Maryland 21218</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/3/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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WAVE, Baltimore, Maryland

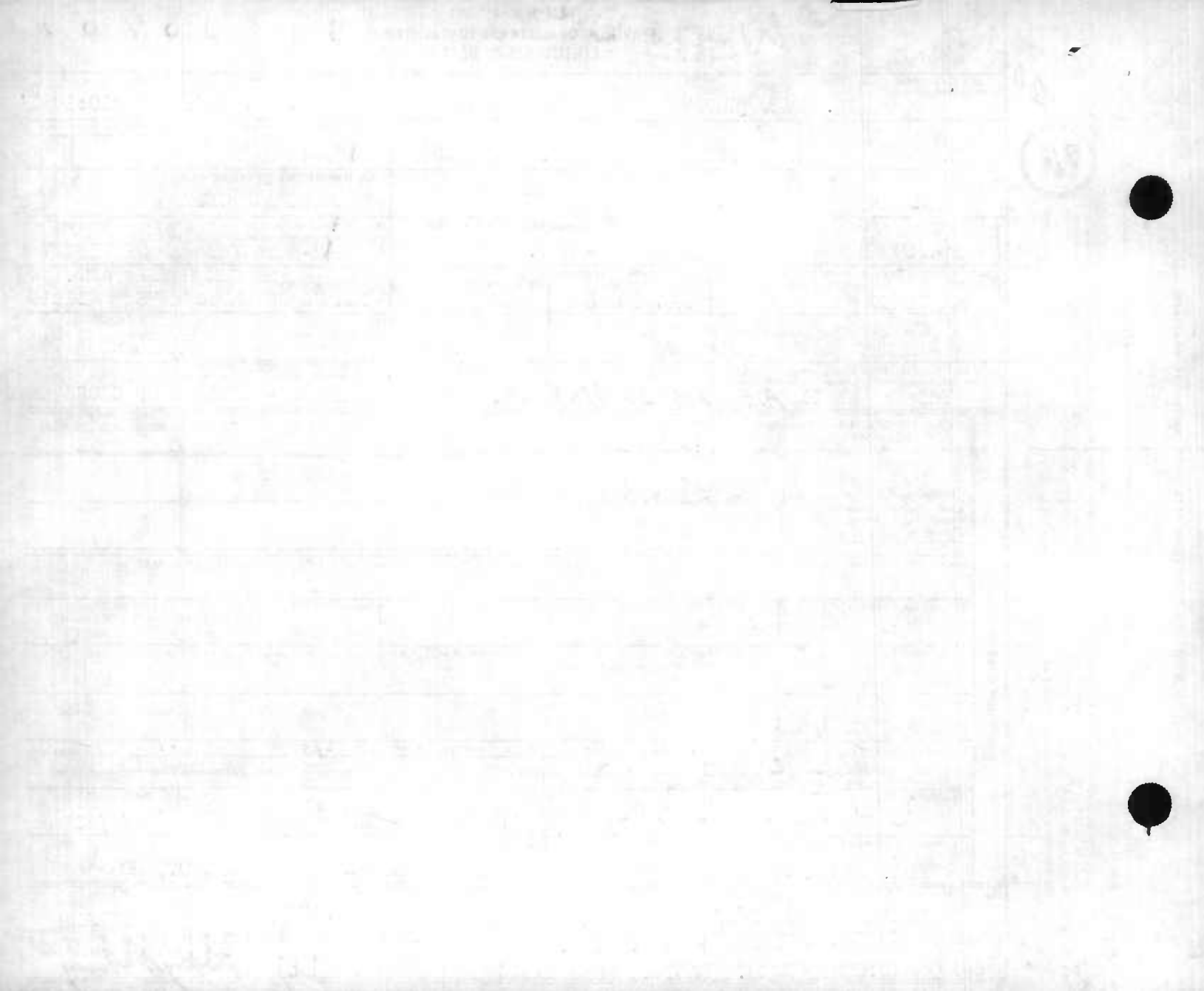
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 / 6 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>DR. SAUL (BUDDY) BLUMENTHAL  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 5, 1981  |  | 2b. HOUR P. M.<br>10:10 M.   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>NOV. 24, 1926  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HARPER HOUSE - APT. 606 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMPLOYED   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>DENTISTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY BALTIMORE  |  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>HARPER HOUSE, APT. 606<br>VILLAGE OF CROSS KEYS #21210  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>HENRY BLUMENTHAL   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LILLIE FAMILANT  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  |  |  | 16b. SOCIAL SECURITY NO.<br>WWII A.F. 213-20-9383  |  | 17 INFORMANT MRS. ABBEY BLUMENTHAL<br>APT. 606 HARPER HOUSE - VILLAGE OF CROSS KEYS #21210                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>2396<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <u>Braintumor</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (if (this hospital) attended the deceased from <u>11-10</u> , 19 <u>80</u> , to <u>2/5</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased on <u>2-19</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.             |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Ken Malinow</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br>3/6/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. KEN MALINOW   |  |  |  | 22e. ADDRESS<br>15 QUADRANGLE BALTO., MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3/8/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHIZUK AMINO   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |  |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. Brady</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  | 8106770  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vera P. Boncewich  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 21 81 |  | 2b. HOUR<br>12.45 P.M.   |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>W  |   | 5 DATE OF BIRTH MONTH DAY YEAR<br>9 17 1889  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USSR   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>—   |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Petroff  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>Katherine   |   | 13e. STREET ADDRESS<br>349 Bonsal Street   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>220-14-0832   |   | 17 INFORMANT<br>Sophie Rhinier   |  | ADDRESS<br>349 Bonsal Street Balto., MD. 21224   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>4960<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive Pulmonary disease</u> |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-3-81 to 3-21-81, that (I) (we) last saw the deceased alive on 3-20-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>[Signature]   |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br>3-21-81  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DARSHAN S. SALUJA  |  | 22e. ADDRESS<br>1600 MT Royal Ave Balto 21217  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/24/1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Russian Orthodox   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Elkridge Maryland   |  |  |
| 24 FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |
| 26 FUNERAL HOME ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |  |  |   |  |  |  |  |  |





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

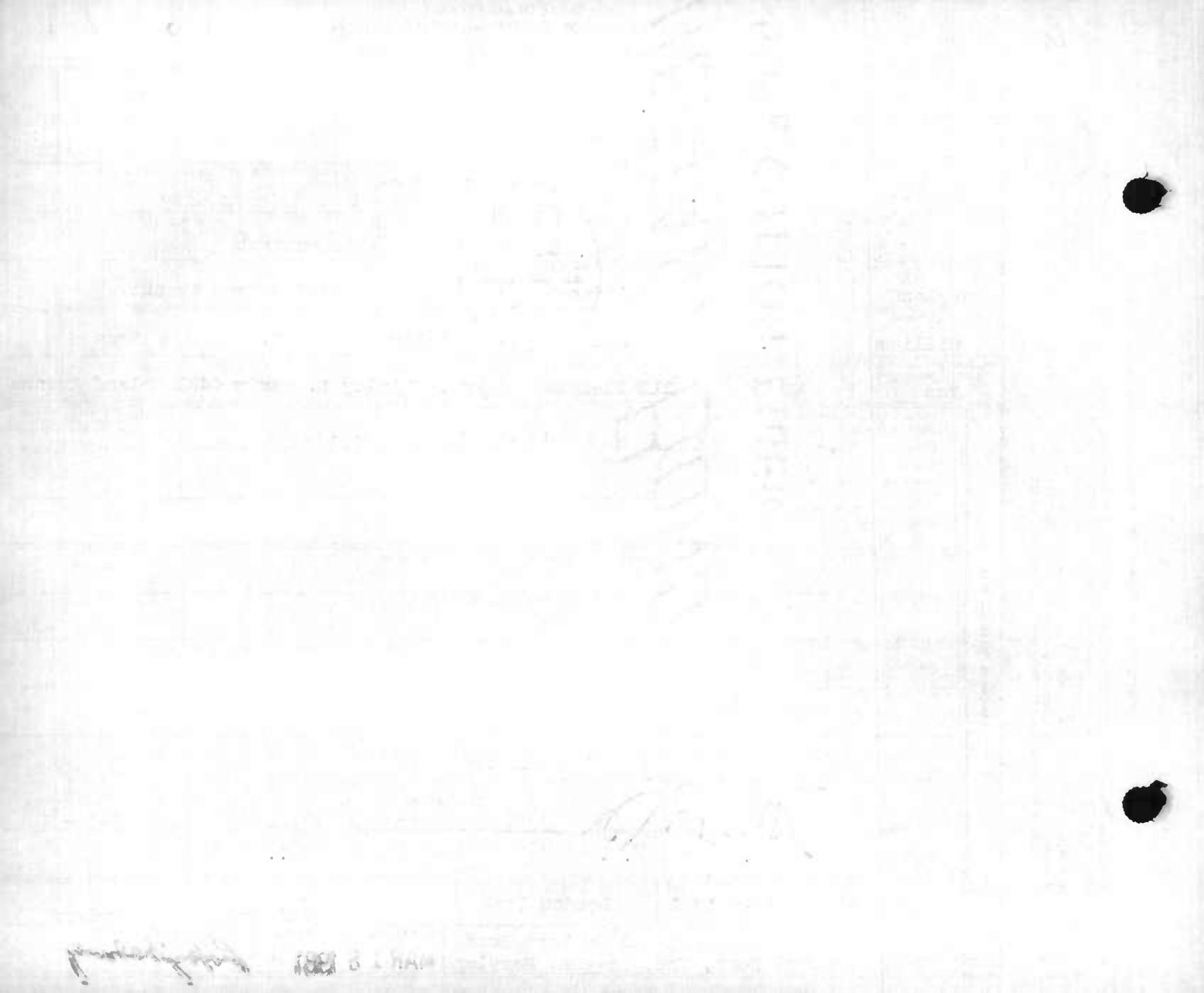
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |
|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 06771   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |   |
| ROBERT L. BORIG   |  | 3 16 19 81  |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.   |
| male  | white  | Dec. 18, 1926   | 54  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |
| Maryland  | U.S.A.   |   | Baltimore City  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |
| Baltimore   | 4401 Roland Ave.   | Accountant  |   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland  |  | Baltimore   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  | 13e. STREET ADDRESS   |   |
| William F. Borig  | Emily C. Mann  | 4401 Roland Avenue  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |
| Yes   | WW 2   | Mrs. Shirley L. Borig 4401 Roland Avenue  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL<br>SIGNATURE   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  | DATE<br>SIGNED  |   |
| Ann M. Dixon, M.D.  |  | 3-16-81   |   |
| ADDRESS   |  | 111 Penn St.  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |
| Cremation   | 3-19-1981  | Loudon Park   | Baltimore Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |
| Ruck Towson Funeral Home, Inc.  | 1050 York Road<br>Towson, Maryland   |   | MAR 18 1981   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

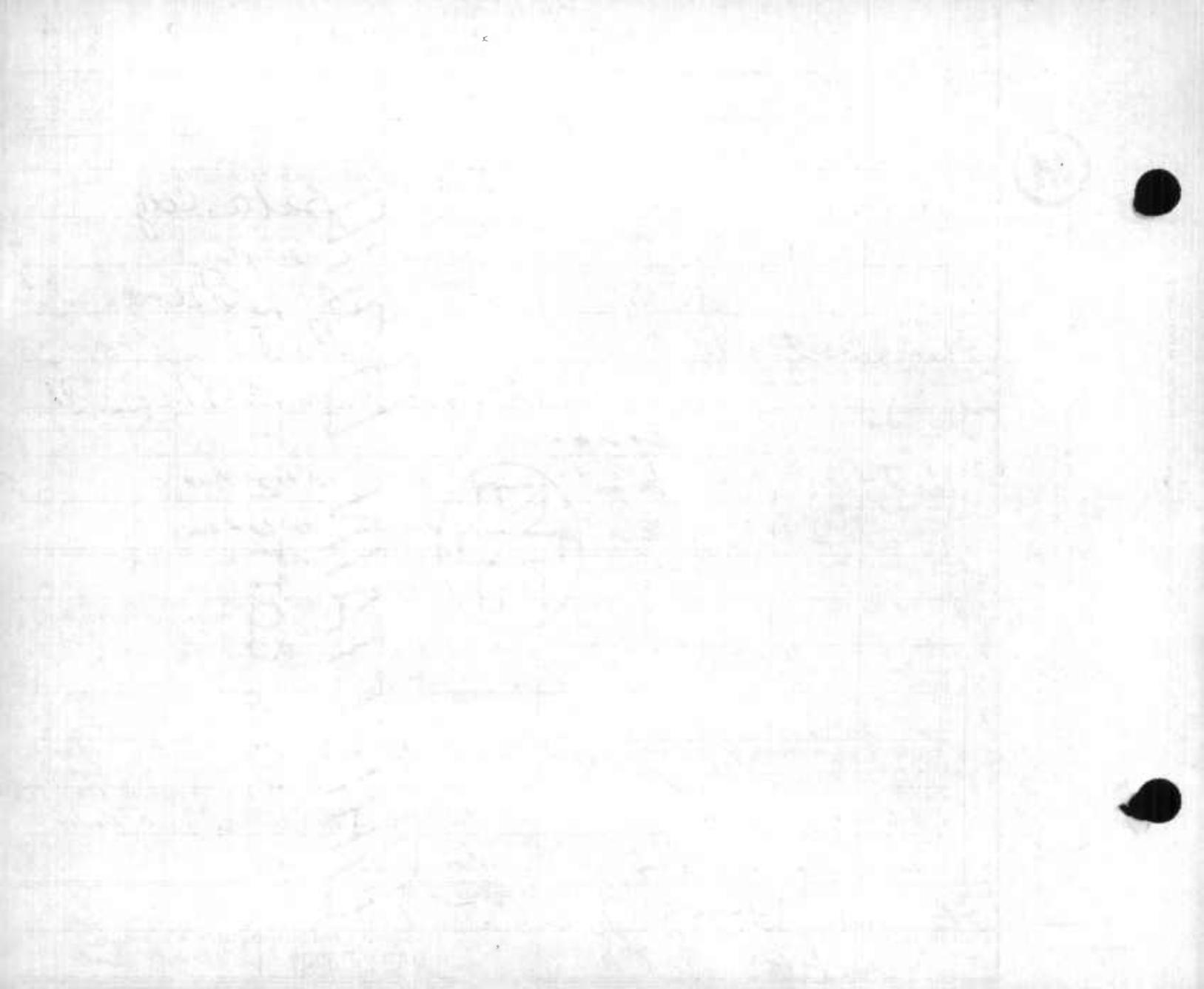
1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |                                      |  |                                   |  |
|--|--|--|--|---|--------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH                                |   |                                      | 2b. HOUR   |                                   |  |
| George P. Boston   |  |  | 3 21 81  |   |                                      | 6:55 P.M.  |                                   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                  |   |                                      | 7. IF UNDER 1 YEAR   |                                   |  |
| Male   | Negro  | 9 18 30  | 50   |   |                                      | MONTHS DAYS HOURS MIN.   |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                   |  |
| Maryland   | U.S.   |  |  |   | Baltimore City MD.                   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTO  | Bon Secour   |  |  | unemployed  |                                      |  |                                   |  |
| 13a. STATE   |  |  | 13b. COUNTY                                      |   |                                      | 13c. CITY OR TOWN  |                                   |  |
| MD.  |  |  | BALTO  |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                         |   |                                      | 13e. STREET ADDRESS  |                                   |  |
| George P. Boston   |  |  | Emma Curtis Boston                               |   |                                      | 1509 Madison St  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.                         |   |                                      | 17. INFORMANT ADDRESS  |                                   |  |
|  |  |  | 220-24-3827                                      |   |                                      | Delmar Turner 1509 Madison St  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |                                      |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |                                      |  |                                   |  |
| IMMEDIATE CAUSE (a) 4275   |  |  |  |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulm Damage to 6th rib part   |  |  |  |   |                                      |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) C.P. arrest + Pulm embolism   |  |  |  |   |                                      |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |                                      |  |                                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |                                      | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |   |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |                                   |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |   |                                      |  |                                   |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |   |                                      | 21f. LOCATION  |                                   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |                                      | STREET CITY OR TOWN COUNTY STATE   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 19 81, to 3/21, 19 81, that (I) (we) lost saw the deceased alive on 3/21, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                      |  |                                   |  |
| 22b. SIGNATURE   |  |  |  |   |                                      | DEGREE   |                                   | 22c. DATE SIGNED   |
| Holmes & Co. 6 months  |  |  |  |   |                                      |  |                                   | 3/24/81  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |                                      | 22e. ADDRESS   |                                   |  |
| Robert A. SABA-VOY   |  |  |  |   |                                      | Bon Secour   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |   |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |  |
| Burial   |  |  | 3, 28, 81  |   |                                      | St. Ann's Catholic   |                                   |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR                    |   |                                      | 25b. REGISTRAR'S SIGNATURE   |                                   |  |
| Name ADDRESS   |  |  | MAR 26 1981                                      |   |                                      | P. J. Kelly  |                                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 6 7 7 3                                  |  |                    |  |
|---|--|--|--|--|--|---|--|--|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR                                       |  |                    |  |
| Elizabeth R. Bourne   |  |  |  | 3 29 1981  |  |   |  | 9:30 AM  |  |                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                             |  | 8. IF UNDER 24 HRS |  |
| Female  |  | Black  |  | 5 12 1908  |  | 72 YRS.   |  | MONTHS   |  | DAYS               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                    |  |
| Virginia  |  | U. S. A.   |  |  |  | Baltimore City MD.  |  |  |  |                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                    |  |
| Baltimore   |  | 2316 Whittier Avenue   |  | School-Teacher   |  | Balto. Pub. Sch.  |  |  |  |                    |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                            |  |                    |  |
| Maryland  |  | Baltimore  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | Maryland 21217<br>2316 Whittier Ave. Baltimore |  |                    |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |  |  |                    |  |
| Kenneth   |  | Rayner   |  | 16b. SOCIAL SECURITY NO  |  |   |  |  |  |                    |  |
|   |  | Lucress  |  | 214-40-5680  |  |   |  |  |  |                    |  |
|   |  | Douglass   |  | 17. INFORMANT  |  |   |  |  |  |                    |  |
|   |  |  |  | ADDRESS Balto., Md. 21217  |  |   |  |  |  |                    |  |
|   |  |  |  | Wellington D. Parker 2316 Whittier Avenue  |  |   |  |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  |                    |  |
| PART 1. DEATH WAS CAUSED BY   |  |  |  |  |  |   |  |  |  |                    |  |
| IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 5 MIN.   |  |  |  |  |  |   |  |  |  |                    |  |
| 4100  |  |  |  |  |  |   |  |  |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                    |  |
| (b) <u>Arteriosclerotic heart disease</u> SEVERAL YEARS   |  |  |  |  |  |   |  |  |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                    |  |
| (c)   |  |  |  |  |  |   |  |  |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |  |  |   |  |  |  |                    |  |
| <u>Hypertensive Vascular disease + diabetes</u>   |  |  |  |  |  |   |  |  |  |                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                    |  |
| N/A   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                    |  |
| 21a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. LOCATION   |  |  |  |                    |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | LEADER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2   |  | CITY OR TOWN COUNTY STATE   |  |  |  |                    |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |                    |  |
| 21e. INJURY OCCURRED  |  | 21f. PLACE OF INJURY   |  | 21g. LOCATION  |  | 21h. DATE SIGNED  |  |  |  |                    |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  | 3/30/81   |  |  |  |                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> 19 <u>81</u> to <u>3/29</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |  |  |  |  |   |  |  |  |                    |  |
| 22a. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>                                  |  | 22b. DATE SIGNED  |  |  |  |                    |  |
| Donald Stewart  |  | M.D.   |  |  |  | 3/30/81   |  |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. REGISTRAR'S SIGNATURE                     |  |                    |  |
| Burial  |  | 4-4-1981   |  | Maryland National Mem.   |  | Laurel  |  | Maryland                                       |  |                    |  |
| 24. FUNERAL DIRECTOR  |  | NAME   |  | ADDRESS  |  | DATE REC'D. BY REGISTRAR  |  | 25. REGISTRAR'S SIGNATURE                      |  |                    |  |
| Herbert E. Nutter Funeral Home  |  | 3035 W. North Ave.   |  | Balto., Md. 21216  |  | MAR 31 1981   |  | [Signature]                                    |  |                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROBERT B. BOWMAN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 08, 1981</b>        |  | 2b. HOUR<br><b>11:30 AM</b>                                     |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 15 35</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>  |  |   | 13c. COUNTY<br><b>Baltimore</b>                                     | 13d. CITY OR TOWN<br><b>Baltimore</b>  | 13e. STREET ADDRESS<br><b>730 N. Monroe Street</b>              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Stewart</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Bowman</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-3886</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Ella Thompson 730 N. Monroe Street</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Thrombotic dysfunction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma metastatic to cerebellum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Probable lung cancer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>3/3/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Posterior fossa tumor</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> 19 <b>81</b> , to <b>3/8</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) did (did not) view the body after death).  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>R North</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/8/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R NORTH</b>  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/13/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem</b>                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD.</b>  |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM.C.MARCH F/H INC.</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1981</b>                                  |   |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. Hebrun</b>                                    |   |



RECEIVED  
MAR 10 1941

RECEIVED  
MAR 10 1941

RECEIVED  
MAR 10 1941

RECEIVED  
MAR 10 1941

RECEIVED  
MAR 10 1941

MAR 10 1941



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 6 7 7 5  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAWRENCE J BOWINKELMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 4 81</b> |   |  | 2b. HOUR<br><b>2 40 P.M.</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>56. BALTO. GEN. HOSP.</b>                         |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouseman, Groceries</b> |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>City</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |  |
| 13e. STREET ADDRESS<br><b>1814 LIGHT ST.</b>   |  |   |  |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS --- Bowinkelman</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie --- Cain</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. 2</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary E. Bowinkelman, Same as above</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Auto respiratory Failure</b><br><b>3320</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Auto pulmonary edema</b><br>(c) <b>Parkinson's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1-19</b> , 19 <b>81</b> , to <b>3-4</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>3-4</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (view the body after death).  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>H. Gattlieb</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3-4-81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Gattlieb</b>  |  | 22e. ADDRESS<br><b>3001 South Hanover St. Baltimore, MD</b>   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 9, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. [Signature]</b>                                       |  |  |



*Handwritten signature*

MAR 5 1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

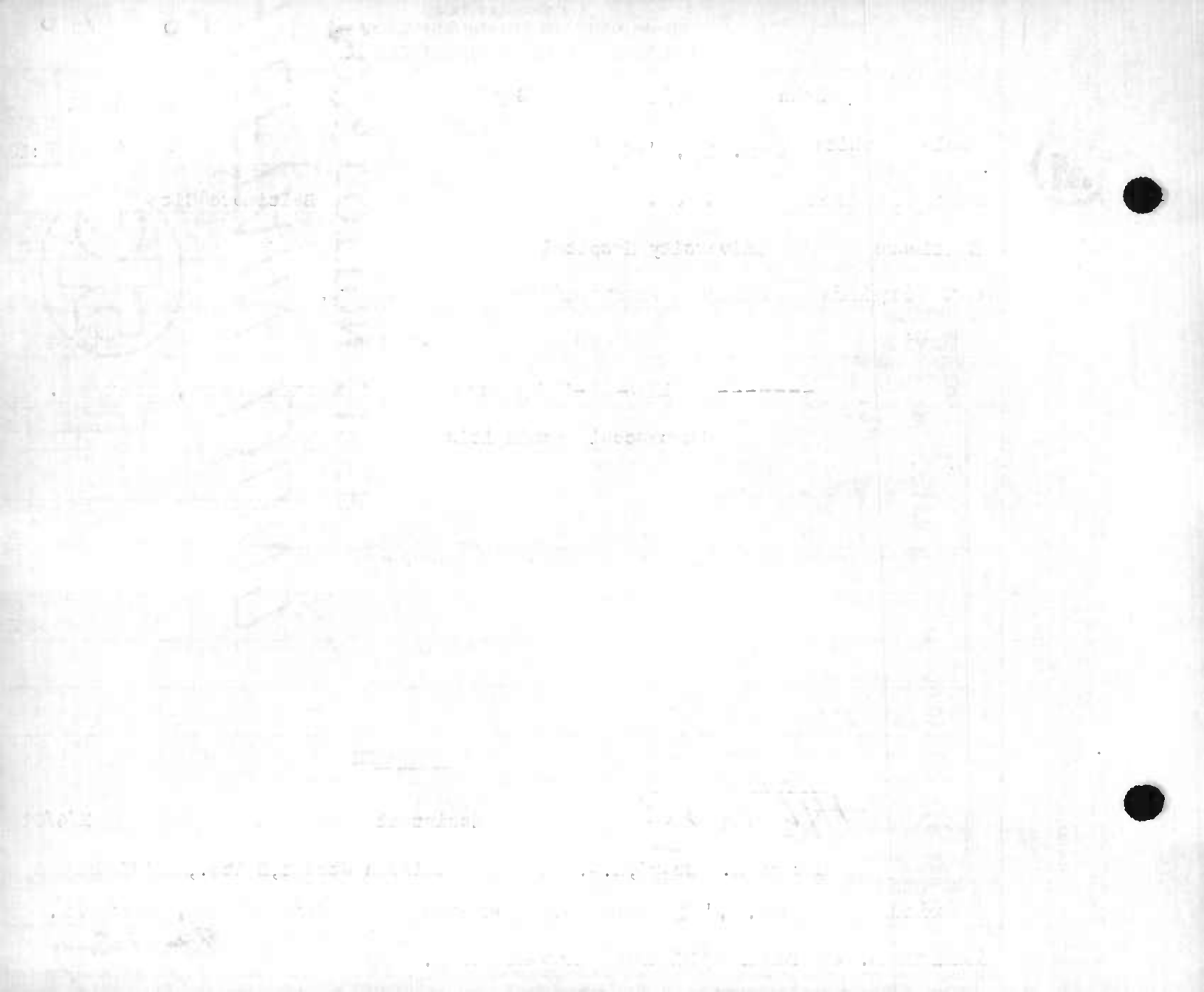
DHMH-17  
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15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>John   |  | MIDDLE<br>David   |  | LAST<br>Boyd  |  | 2a. DATE KNOWN OF DEATH   |  | ESTIMATED<br><input checked="" type="checkbox"/> MONTH<br>DAY<br>YEAR<br>3 4 19 81  |  | 2b. HOUR<br>M<br>8:10A  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 19, '61 20 YRS.  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN. |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 4 19 81                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City    |  | 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Education   |  | 13a. STATE<br>West Virginia                                     |  | 13b. COUNTY<br>Berkley  |  | 13c. CITY OR TOWN<br>Martinsburg                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rt. #4   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>David Boyd   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Waters |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-60-2725                   |  | 17. INFORMANT<br>David Boyd   |  | ADDRESS<br>Martinsburg, West Va.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumococcal meningitis</u><br>3301<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |   |  |   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH* DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>H. R. Guard</i>   |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br>3/4/81   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |   |  | ADDRESS<br>111 Penn Street, Balto., MD 21201  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>Mar. 7, '81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rosedale Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Martinsburg, West Va.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson   |  |   |  | ADDRESS<br>8521 Loch Raven Blvd.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McBrady</i>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 7 7 7   |  |  |  |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR  |  |  |  |
| FIRST MIDDLE LAST<br>Florence E. Bradley   |  |   |  | MONTH DAY YEAR<br>3-31-81  |  |   |  | 1559 M  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 5 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinner Hosp of Balt. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>md   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2333 McCulloh St.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Moody  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amanda Garrett  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>216-01-0962  |  | 17. INFORMANT<br>Barbara Bradley  |  | ADDRESS<br>2333 McCulloh St.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac asystole</u><br>2069<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septicemia (probable)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myelogenous monocytic leukemia.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>81</u> , to <u>3/31</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>2/31</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Jonathan Levi  |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED<br>3/31/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jonathan Levi   |  |   |  | 22e. ADDRESS<br>Belvedere at Green Spring Baltimore MD   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>4/4/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |   |  | ADDRESS<br>1101 E. North Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 2 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela Hardy  |  |

1004-3 844

100-3-84A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06778

FOR  
STATE  
REGISTRAR

REG. NO.

|   |                  |  |   |   |  |   |  |   |  |   |  |
|---|------------------|--|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lucille or LUCY  |                  | FIRST<br>E.  |   | MIDDLE<br>BRADY   |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 3-11-81 |  | 2b. HOUR<br>M<br>P M                            |  |
| 3. SEX<br>female  | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 14 1885  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>96 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br>3-11-81   |  | 2d. HOUR<br>P M                                 |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1220 Sheridan Avenue |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Md.   |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1220 Sherdian Ave  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John T Brady  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy E. Smith  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |                  | (IF YES, GIVE WAR OR DATES)  |   | 16b. SOCIAL SECURITY NO.<br>220 44 5608   |  | 17. INFORMANT<br>ADDRESS<br>Lillian M. Gerding 708 Hatherleigh Rd.                              |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>(b) _____<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.  |                  |  |   |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |  |   |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  |  |   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                                      |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |   |  |   |  |   |  |
| ACTUAL<br>SIGNATURE <u>Margarita A. Korell</u>  |                  |  |   | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | DATE<br>SIGNED 3-12-81  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Margarita A. Korell, M.D.  |                  |  |   | ADDRESS 111 Penn Street   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial   |                  | 23b. DATE<br>3/16/1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn Cemetery  |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore  |  | 23e. STATE<br>Md                                |  |
| 24. FUNERAL DIRECTOR<br>NAME Mitchell-Wiedefeld Home 6500 York Rd,<br>ADDRESS Balto, Md.  |                  |  |   |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 18 1981  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

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(VRA15 ME (5))  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mable (Mabel)</b>  |  | FIRST<br><b>Braxton</b>  |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 81</b>   |  | 2b. HOUR<br><b>4:25 P<sub>M</sub></b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 9 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2527 Woodbrook Ave.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Violet C. Fisher 1618 N. Fulton Ave.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Schrochoid Hemorrhage</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease</b> Years<br>Approximate interval between onset and death: <b>4 months</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Congestive heart failure</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 71</b> to <b>3/14</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Louis E. Grenzer</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Louis E. Grenzer</b>   |  | 22e. ADDRESS<br><b>1101 N. Calvert St</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/18/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat'l Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel MD</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8106780  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(Anna) <b>Annie R. Breadman</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 19 81</b>  |  |  |  |
| 3 SEX <b>F</b>  |  |   |  | 2b. HOUR<br><b>10:30AM</b>  |  |  |  |
| 4. RACE <b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 9 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>St George S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(GIVE WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>201 N. Broadway</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>0</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-30-0056 T</b>   |  | 17. INFORMANT ADDRESS<br><b>Louise Bristol, 405 Poplar Grove St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis.</b><br>4360                                   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/19/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/ 24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Deer Park Mem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave.</b>  |  |   |  | 25a. DATE AND BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 30 1981</b> <i>[Signature]</i>                                  |  |  |  |

*[Handwritten signature]*

MAR 30 1961

at Central Home of the United States  
MAR 30 1961

trial

24 MAY 1961

of

2 April 1961

1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |   |  |  |  |  |  |  |  | REG. NO. 06781 |  |
|--|---------------|---|--|--|--|--|--|--|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) George Bridgewater   |               |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 7 1981                  |  | 2b. HOUR 9:30 A M  |  |                |  |
| 3. SEX Male  | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1938  | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.                            | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.           | 2c. DATE PRONOUNCED DEAD 3 7 1981  |  | 2d. HOUR 9:30 A M  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.  |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.   |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY Trucking                 |  |                |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY P.G. 13c. CITY OR TOWN Deanwood Park  |               |   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 13e. STREET ADDRESS 4714 Deanwood Dr.                      |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ninrod Bridgewater   |               |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Robinson       |  |  |  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No  |               | 16b. SOCIAL SECURITY NO. 220-34-8821  |  | 17. INFORMANT ADDRESS Lois Bridgewater-Same as # 13 above  |  |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt Injury to Head<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |               |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |               |   |  |  |  |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |               |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |  |  |  |  |  | 20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               |   | 21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 4:45 P.M. 3 1 1981     |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of motorcycle/auto impact |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |               |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street |  |  | 21f. LOCATION STREET Eastern Ave. & 50th Street, N.E.,   |  |  | COUNTY STATE Washington, D.C.  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |               |   |  |  |  |  |  |  |  |                |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |               |   | TITLE (SPECIFY) M.D. Assistant                                     |  |  | MEDICAL EXAMINER   |  |  | DATE SIGNED 3/8/81   |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |               |   | ADDRESS 111 Penn Street  |  |  |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |               |   | 23b. DATE 3-12-81  |  | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park |  |  | 23d. LOCATION CITY OR TOWN Highland Park, Md. COUNTY STATE |  |                |  |
| 24. FUNERAL DIRECTOR NAME H. S. WASHINGTON & Sons  |               |   | ADDRESS 4925 BURROUGHS AVE. W.C.F.                                 |  |  | 25a. DATE RECEIVED BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |                |  |

BP

COAST GUARD

Station

Midway

Boat

Boat

100-00-0000

100-00-0000

100-00-0000

100-00-0000

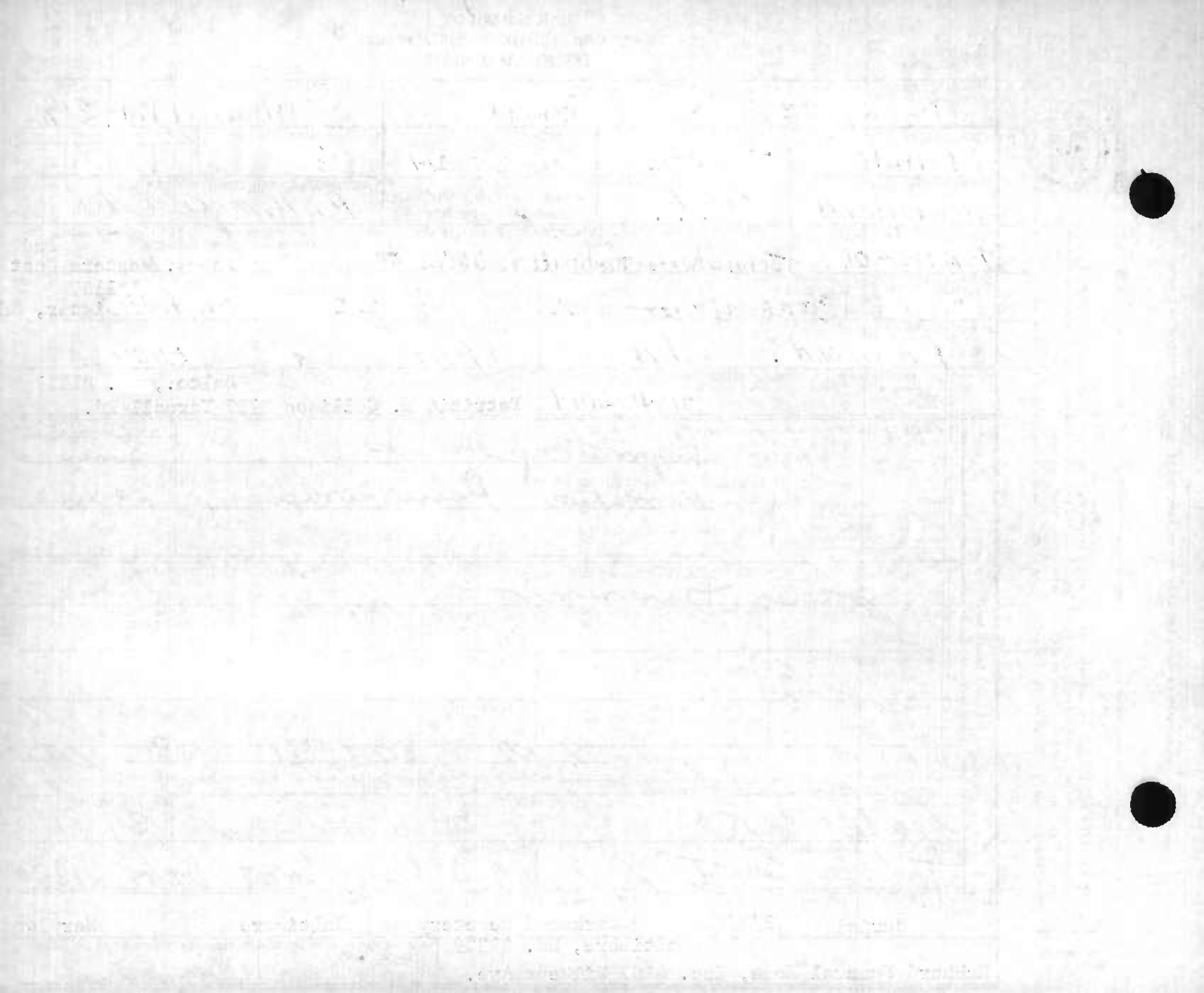
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 / 8 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                              |  |  |
|---|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DOROTHY MAY BRITTON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 1, 1981</b> |   | 2b. HOUR<br><b>3:10 A.M.</b> |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 25 14</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Seaton Medical Center 611 Charles St</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sewing Machine Op. Western Coat</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pad</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Carroll Westminster</b>  |   | 13c. CITY OR TOWN<br><b>Westminster</b>   |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob R. Pike</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Rubee</b>   |   | 13e. STREET ADDRESS<br><b>2117 Don Avenue Westminster, Md</b>   |                              | 13f. CITY OR TOWN<br><b>Westminster, Md</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-6014</b>   |   | 17. INFORMANT<br><b>Patricia M. Collison 2797 Yarnall Rd.</b>   |                              | ADDRESS<br><b>Balto., Md. 21227</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 min</b><br><b>24 hrs</b> |  |  |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i)<br><b>Brain Tumor</b>  |  |  |   |   |                              |  |  |
| 19a. DATE OF OPERATION<br><b>2-20-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Brain Tumor</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>611 S. Charles Street Baltimore Maryland</b>  |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-20-80</b> to <b>3-1-81</b> , that (I) (we) last saw the deceased alive on <b>3-1-81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>John S. Zebley M.D.</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3-1-81</b>   |                              | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John S. Zebley M.D.</b>  |  |
| 22e. ADDRESS<br><b>611 S. Charles Street Balto 21230</b>  |  | 22f. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |   | 22g. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |                              | 22h. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1981</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/4/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>   |  | ADDRESS<br><b>Baltimore, Md. 21229</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1981</b>  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia M. Collison</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                                      |  |   | 8 1 0 6 / 8 3  |   |   |  |
|--|--------------------------------------|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |                                      |  |   | REG. NO.   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mottie Brockington   |                                      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3/4/81   |   | 2b. HOUR<br>6:30 AM   |  |
| 3. SEX<br>F  | 4. RACE<br>B                         | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 15 17   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 63 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City, Baltimore MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Park Hill Convalescence |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laundry  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |                                      |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Cecil Taylor  |                                      | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lizzie Nelson  |   | 13d. STREET ADDRESS<br>787 George St.  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                                      | 16b. SOCIAL SECURITY NO.<br>248-20-718   |   | 17. INFORMANT ADDRESS<br>Evelyn Williams 787 George Street   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Cerebral Vascular Accident<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Cerebral Vascular Accident                                     |                                      |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                                      |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 18 to March 19 81, that (I) (we) lost saw the deceased alive on March 3 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                      |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Dr. E. G. Ayoso  |                                      | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. E. G. Ayoso   |                                      | 22e. ADDRESS   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |                                      | 23b. DATE<br>3/9/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Florence S.C.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. C. MARCH F/H INC. 1101 E. North Ave.   |                                      |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>Mary Kennedy  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 8 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Patrick J. Brogan  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1981                     |  | 2b. HOUR<br>pm<br>11:20                                      |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 1, 1908  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 7. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore, Md.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk | 12b. KIND OF BUSINESS OR INDUSTRY<br>U. S. Post Office   |  |
| 13a. STATE<br>Md.   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Balto.   | 13d. STREET ADDRESS<br>4025 Wilkens Ave. 21229   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Patrick Brogan  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Bourke  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 217-07-9380   |   | 17. INFORMANT<br>ADDRESS<br>William Brogan 4025 Wilkens Avenue   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>cancer of the rectum |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>hours     |
| 19a. DATE OF OPERATION<br>-   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)            |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>J. A. Singer  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>3/16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John A. SINGER   |   | 22e. ADDRESS<br>900 Canton Ave  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>3-19-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland   |   | 24. FUNERAL DIRECTOR<br>NAME<br>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 18 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>R. J. H. H. H.  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 330-1111.

1891 8th 8AM

Items #10a-22a Film G554 4/2/81 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06785

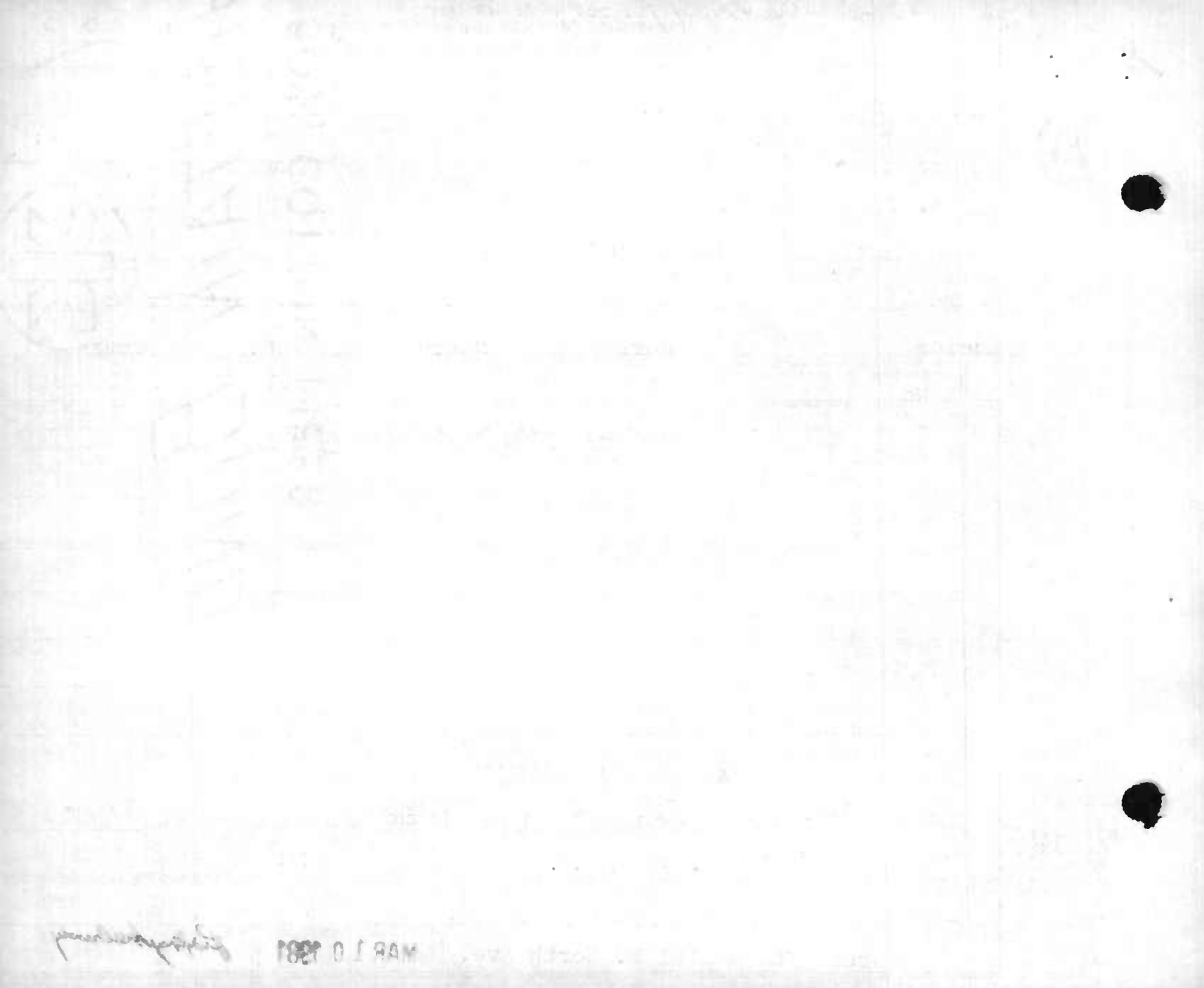
|  |  |   |   |   |
|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alma J. Brown</b>  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3 8 19 81</b>   |   | 2b. HOUR<br><b>8:42 A M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 6 1939</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>41 YRS.</b>  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |
| 13a. STATE<br><b>Md</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Md</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>531 E. 21st Street</b>                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lucius Dorsey</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nancy M. Cowan</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-38-4799</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Shandra Terrell 531 E. 21st St.</b>                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292 Arteriosclerotic Cardiovascular Disease</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |   |   |   |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |   | DATE SIGNED<br><b>3/8/81</b>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |  | ADDRESS<br><b>111 Penn Street</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3/13/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                 |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1981</b>                                 |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

0908



*Handwritten text, possibly a signature or initials.*

MAR 10 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |  |
|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DONNEL (Donnell) BROWN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/31/81</b> |   |  | 2b. HOUR<br><b>6:30 PM</b>   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 10 59</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b> |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>616 N. Mount Street</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Odell v Brown</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sylvester - Brown</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unknown</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-74-8740</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Sylvester Brown 616 N. Mount St.</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>5/7/2 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Recent GI bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis + HTN Hypertension</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>STOMACH Ache</b> |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>81 3/31 81</b>  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>81</b> , to <b>3/31</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Donnell</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/01/81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm. Donnell</b>  |  | 22e. ADDRESS<br><b>1540 W. Balt &amp; Bto 462223</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/4/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT Auburn</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, MD 21201</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. Donnell</b>   |  | 24b. ADDRESS<br><b>1540 W. Balt &amp; Bto 462223</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm. Donnell</b>   |  |  |

BP

1999年12月

[illegible]

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23

San Antonio Hospital

007P-AC-BIS

1010

892



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 / 8 /   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><b>ELMER WILLIAM BROWN</b>  |  |   |  | MONTH DAY YEAR HOUR<br><b>3 29 81 4:45 p.m.</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 2 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>85</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE MARYLAND</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Brown</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Robinson</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW1</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Medical Records</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>5/20</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>pneumothorax</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>rheumatoid arthritis</b>   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min</b><br><b>2 days</b><br><b>&gt;20 yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>chronic VTI chronic renal failure, atrial pacemaker, AI murmur</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 7</b> 19 <b>81</b> , to <b>MARCH 29</b> 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>MARCH 29</b> 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>RE Gangarosa MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3-30-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RE Gangarosa MD</b>  |  |   |  | 22e. ADDRESS<br><b>Loch Raven Veterans' Administration Hosp</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-3-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Brown/ Thompson F.H. 1913 W. Balto. St.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 1 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 8 8

REG. NO.

|   |  |  |  |   |   |  |   |  |   |  |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frances Helen Brown</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 30 81</b>                    |   |   | 2b. HOUR<br><b>10 p.m.</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 13 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>68 YRS.</b>  |   | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1211 Hollins Street</b> |  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |   |  |
| 13a. STATE<br><b>Md</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1211 Hollins Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Hughes</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Brooks</b>      |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217 07 9244</b>                           |   | 17. INFORMANT ADDRESS<br><b>Mary Johnson 1211 Hollins Street</b>                              |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1629</b> <i>Progression of liver cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastasis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive pulmonary disease</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 YEAR</b><br><b>7 YEARS</b> |  |  |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2/15 8 3/30 81</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1940 W. Baltimore St Baltimore Md</b> |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15 81</b> to <b>3/30 81</b> , that (I) (we) lost <b>the deceased</b> above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/9/81</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm. F. Thompson</b>   |  |  | 22e. ADDRESS<br><b>1940 W. Baltimore St Baltimore Md 21223</b>           |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>4-3-1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Brown/Thompson F. H. 1913 W. Baltimore St</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1981</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 6 / 8 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George A. Brown   |  |   |  | 2a. DATE OF DEATH<br>March 25, 1981   |  | 2b. HOUR<br>3:00A M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>12 20 20  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  |
| 7a. BIRTHPLACE (COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>- - -   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances Browne   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>No  |  |  |  |
| 16a. SOCIAL SECURITY NO.<br>217-12-6581   |  | 17. INFORMANT ADDRESS<br>Palestina Tubman 1531 Montepelier  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Urinary Bladder</u><br>1889<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 12</u> , 19 <u>81</u> , to <u>March 25</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 25</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>G. Girgis, M.D.   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3-25-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Gigi Girgis, M.D.  |  |   |  | 22e. ADDRESS<br>C/O Maryland General Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/28/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at our office.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 6 / 9 0  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |   |   |  |
|--|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hallie F. Brown   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 11 81 |   |   | 2b. HOUR<br>M   |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 4 27  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1419 Edmondson Ave. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |   |   |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltio.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br>1419 Edmondson  |  |  |  |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James H. Brown   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Betty Turner   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>244-26-7571   |  | 17. INFORMANT<br>Janice Wright  |   | ADDRESS<br>3410 Carrington Hill Cir.  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |   |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |   |   |   |  |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>  |  |  |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>  |  |  |  |   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease 10 years</u>   |  |  |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> , 19 <u>80</u> , to <u>12-19</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>12-19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. |  |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br>John T. Chissell, MD   |  |  |  | DEGREE  |   | 22c. DATE SIGNED<br>3/13/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John T. Chissell, MD  |  |  |  | 22e. ADDRESS<br>940 W North Ave 21217   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/16/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Md.                                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |  |  | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, giving usual directions, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 7 9 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>LAKESHA</b>  |  | MIDDLE<br><b>BROWN</b>  |  | LAST<br><b>BROWN</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 15, 1981</b>                         |  | 2b. HOUR<br><b>7:50PM</b>  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 5 80</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                             |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto... Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>n/a</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5512 Haddon Ave. Apt. T-4</b>                              |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vernon Fields</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Irene Brown</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>n/a</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Vernon Fields 5512 Haddon Ave.</b>                              |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden unexpected death</b><br><b>3481</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cerebral atrophy</b><br>(c) <b>Multiple episodes of ischemic brain damage</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 min -</b><br><b>6 mos -</b><br><b>6 mos.</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Sepsis, Bronchopulmonary dysplasia</b>   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/15, 5/10, 8/19, 9/10/80</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Esophageal atresia</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 13</b> 19 <b>80</b> , to <b>Mar 15</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>Mar 15</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.               |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert D. White, M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>3/16/81</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert D. White</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>3/18/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Md.</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett &amp; Son</b>  |  |  |  | ADDRESS<br><b>4600 Liberty Helgh</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>H. H. H. H.</b>   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 / 9 2   |  |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NAOMI BROWN   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 21 81                             |   | 2b. HOUR<br>12:15 AM   |
| 3. SEX<br>FEMALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 MAY 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>US   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSPITAL |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTIMORE   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>3623 LIBERTY HEIGHTS AVE.   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>BENJAMIN SEWELL   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE BAGWELL              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>218-18-6263   |  | 17. INFORMANT ADDRESS<br>ESTHER MEADS 3009 CHESEA TERRACE                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4275<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>STAN 26</u> , 19 <u>81</u> to <u>MARCH 21</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>MARCH 21</u> , 19 <u>81</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>DW Dinnery</u>  |  | DEGREE<br>MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DW DINNERY</u>   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>4-25-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PK.  |  |
| 23d. LOCATION CITY OR TOWN<br>BALTIMORE  |  | COUNTY<br>MARYLAND  |  | STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Phillip Funeral Home</u>   |  | ADDRESS<br><u>721 W. M... St</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1981  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. ...</u>  |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

|   |             |                                    |                               |                            |       |
|---|-------------|------------------------------------|-------------------------------|----------------------------|-------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN)  | COUNTY                     | STATE |
| Burial                                    | 4/2/81      | MD VETERANS                        | Crownsville                   | MD                         |       |
| 24. FUNERAL DIRECTOR                      | ADDRESS     |                                    | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |       |
| Thomas D. Smith                           | 111 Penn St |                                    | APR 1 1981                    | [Signature]                |       |

|   |  |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of leg and chest (handgun)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |

|   |   |   |
|---|---|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY<br>HOUR <u>?</u> AM <u>3</u> MONTH <u>26</u> YEAR <u>81</u><br>P.M. | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>weapon accidentally discharged     |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>at home                  | 21f. LOCATION<br>STREET <u>911 Argonne Drive</u> CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE <u></u> |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |   |   |
| ACTUAL SIGNATURE <u>[Signature]</u> TITLE (SPECIFY) <u>Deputy Chief</u> MEDICAL EXAMINER  |   | DATE SIGNED <u>3/27/81</u>  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Thomas D. Smith, M.D.</u> ADDRESS <u>111 Penn Street, Baltimore, MD. 21201</u>   |   |   |

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Thomas A Brown</u>                                     |  |  | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH <u>3</u> DAY <u>26</u> YEAR <u>1981</u> |   | 2b. HOUR <u></u> M <u></u>   |
| 2. SEX <u>Male</u>   | 4. RACE <u>Black</u>   | 5. DATE OF BIRTH (MONTH DAY YEAR) <u>9 16 05</u>   | 6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.  | IF UNDER 1 YR. MONTHS <u></u> DAYS <u></u>                    | IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Tarboro NC.</u>                               | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.  |   | 2c. DATE PRONOUNCED DEAD MONTH <u>3</u> DAY <u>27</u> YEAR <u>1981</u> |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u>   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>911 Argonne Drive</u> | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>Retired</u>  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Amirican</u>   |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |
| 13a. STATE <u>MD</u>   | 13b. COUNTY <u></u>  | 13c. CITY OR TOWN <u>Baltimore</u>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          | 13e. STREET ADDRESS <u>911 Argonne Drive</u>                  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <u>Thomas Brown</u>                                  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <u>MARTHA DORTER</u>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>yes</u>              |  | 16b. SOCIAL SECURITY NO. <u>215-05-5549</u>  |   | 17. INFORMANT ADDRESS <u>Edna Brown 818 N. Carrollton Ave</u> |  |

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06793



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APR 1 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |   |  |   | 8106794                                       |  |
|--|--|---|--|---|--|--|---|--|---|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |  |   |  |   | REG. NO.                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Brown</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>81</b> |  | 2b. HOUR<br><b>4:45 PM</b>  |  |   |   |  |
| 3. SEX<br><b>m</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baeto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Baeto</b>  |   | 13c. CITY OR TOWN<br><b>Baeto</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>601 Wyman Ave</b> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>unk</b> MIDDLE <b>unk</b> LAST <b>unk</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>unk</b> MIDDLE <b>unk</b> LAST <b>unk</b>  |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>158-09 0047</b>                         |   | 17. INFORMANT<br><b>unk</b> ADDRESS <b>unk</b>                   |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>End Stage Squamous Cell Cancer of Lung &amp; Bow</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD</b>  |  |   |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Dec 19 1980</b> , to <b>March 19 1981</b> , that (1) (we) lost saw the deceased alive on <b>19 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Warren W. Ross MD</b>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>3/13/81</b>   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ross, Warren</b>   |   |   |  |
| 22e. ADDRESS<br><b>Un H</b>  |  |   |  |   |  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  |   | 23b. DATE<br><b>3-17-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board of Md.</b>  |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>                                   |   | 25b. REGISTRAR'S SIGNATURE   |   |   |  |
| ADDRESS<br><b>Baltimore, Maryland</b>  |  |   |  |   |  |  |   |  |   |   |  |





20% COTTON FIBER

WINDMILL BRAND

1-17-11

Amount

Factory Board of Mfg. : 100 to 1000 yards



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

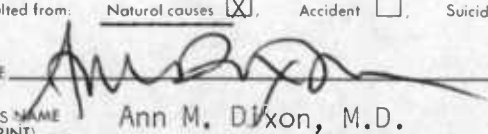

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06195

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE KNOWN OF DEATH   |  |  | 2b. DATE ESTI- MATED  |  |  | 2c. DATE PRONOUNCED DEAD   |  |  | 2d. HOUR  |  |  |
| OLLIE MERVON BRYANT  |  |  | 3. SEX<br>male  |  |  | 4. RACE<br>white  |  |  | 5. DATE OF BIRTH<br>1/11/29  |  |  | 6. AGE (IN YEARS)<br>52 YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City   |  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>503 E. 36th St.  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Courier - Data Processing                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  | 13a. STATE<br>Maryland   |  |  | 13b. COUNTY   |  |  |
| 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  | 13e. STREET ADDRESS<br>503 E. 36th Street   |  |  | 14. FATHER'S NAME<br>Ivan  |  |  | 15. MOTHER'S MAIDEN NAME<br>Myrtle  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |  | 16b. SOCIAL SECURITY NO.<br>218 26 5803   |  |  | 17. INFORMANT<br>Mrs. Rebecca B. Bryant, Balto., Md.  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br>  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  | MEDICAL EXAMINER  |  |  | DATE SIGNED<br>3-23-81   |  |  | EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/25/81  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Md.  |  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212 |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981   |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |   |  |  |  |  |  |   |  |  |

MEDICAL CERTIFICATION

4000 York Road, Balto., Md. 21212  
Henry W. Jenkins & Sons Co.

MAR 23 1961

*[Handwritten signature]*

Gardens of Faith

Baltimore County, Md.

Encl.

8/25/61

*[Handwritten signature]*

Yes Korean

218 28 8803

Mrs. Rebecca B. Bryant, Balto., Md.

Ivan

Bryant

Wynne

Charles

Maryland

Baltimore

500 E. 36th Street

Courier - Data Press, Inc.

North Carolina

USA

1961

MAR 23

10 TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 06196

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>LEROY</u> <u>BUCK</u>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>3</u> <u>25</u> <u>81</u>   |  | 2b. HOUR<br><u>3:00 AM</u>  |  |
| 3. SEX<br><u>male</u>  |  | 4. RACE<br><u>Black</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>03</u> <u>18</u> <u>29</u>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 12a. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>U. of Maryland Hospital</u> |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>truck driver</u>   |  |
| 13a. STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>Calvert</u>   |  | 13c. CITY OR TOWN<br><u>Lusby</u>   |  |
| 14. FATHER'S NAME<br><u>Caleb</u>  |  | 15. MOTHER'S MAIDEN NAME<br><u>Tinnie</u>   |  | 16. SOCIAL SECURITY NO.<br><u>220-16-8109</u>   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>  |  | 17b. SOCIAL SECURITY NO.<br><u>220-16-8109</u>  |  | 17c. INFORMANT<br><u>Carrie K. Buck</u>   |  |
| 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Maryland</u> |  | 13b. COUNTY<br><u>Calvert</u>   |  | 13c. CITY OR TOWN<br><u>Lusby</u>   |  |
| 14. FATHER'S NAME<br><u>Caleb</u>  |  | 15. MOTHER'S MAIDEN NAME<br><u>Tinnie</u>   |  | 16. SOCIAL SECURITY NO.<br><u>220-16-8109</u>   |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>no</u>  |  | 17b. SOCIAL SECURITY NO.<br><u>220-16-8109</u>  |  | 17c. INFORMANT<br><u>Carrie K. Buck</u>   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic myelogenous leukemia -</u><br><u>2051</u> DUE TO, OR AS A CONSEQUENCE OF <u>blast crisis.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1977-present</u>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Cachexia, skin infection.</u>   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 24</u> 19 <u>81</u> , to <u>March 25</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 25</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE<br><u>DeHagge</u>   |  | 22c. DATE SIGNED<br><u>3-25-81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HOGGE</u>  |  | 22e. ADDRESS<br><u>22 S Greene St. Baltimore</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><u>Burial</u>   |  | 23b. DATE<br><u>Mar. 28-81</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Eastern Chapel Cem.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Lusby Calvert Md.</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Spencer E. Sewell</u> <u>Box 31, Prince Frederick, Md.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 31 1981</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Spencer E. Sewell</u>   |  | 25c. REGISTRAR'S SIGNATURE<br><u>Spencer E. Sewell</u>   |  |



Report of the Committee on the Administration of the Government of the District of Columbia, 1901-1902.

16214

0-351 1-201

Eastern Capital Corp.

CT 15912

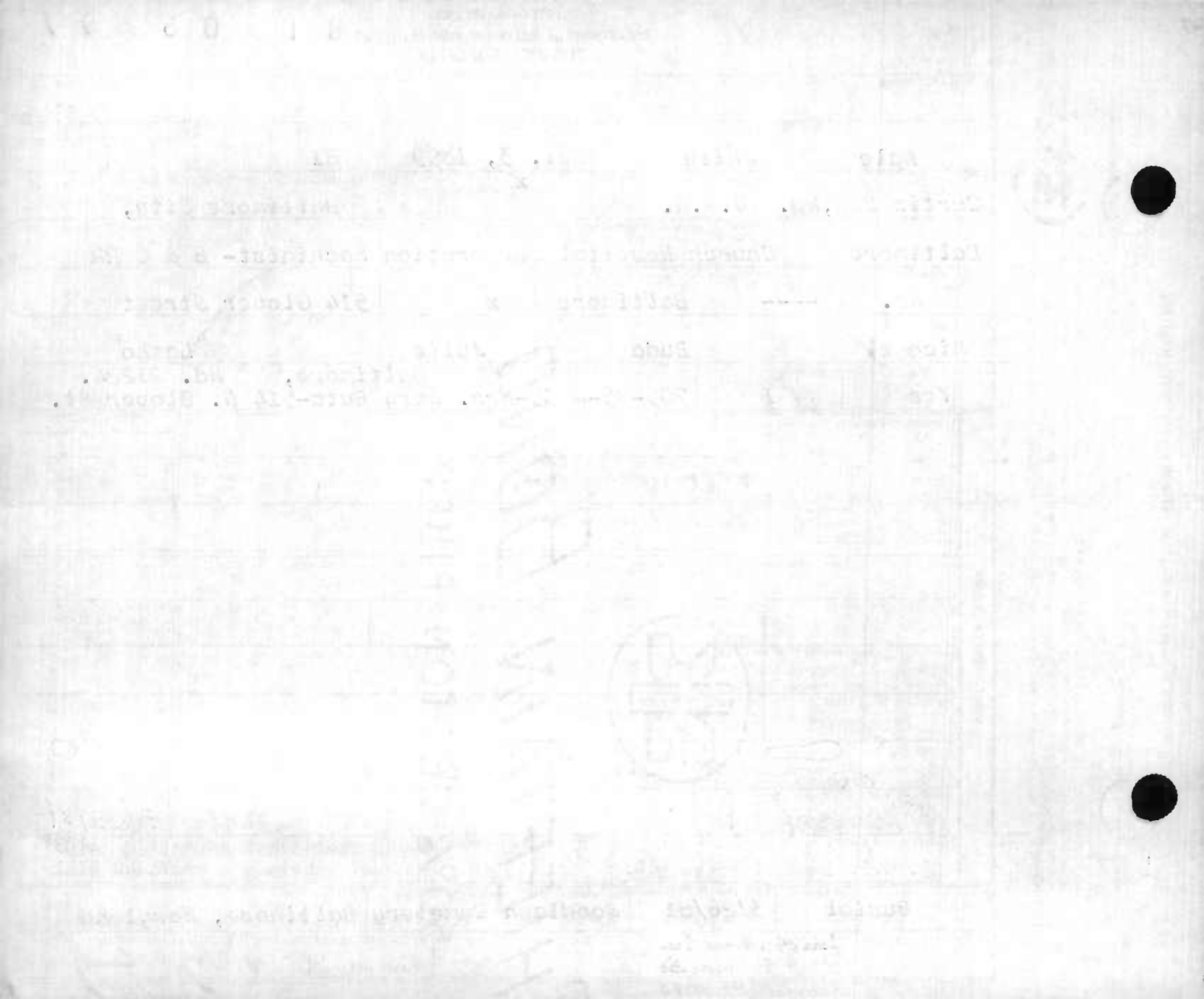
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE   |  |
| MICHAEL BUDA  |  | Male  |  | White   |  |
| 5. DATE OF BIRTH  |  | 6. AGE  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MONTH DAY YEAR<br>Oct. 3, 1899  |  | 81 YRS.   |  | Baltimore City, MD.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Curtis Bay, Md.   |  | U.S.A.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore   |  | Church Hospital Corporation   |  | Machinist- B & O RR   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Md.   |  | ----  |  | Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| Michael Buda  |  | Julie Lasko   |  | 13e. STREET ADDRESS<br>514 Glover Street  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |
| Yes   |  | WW I  |  | Baltimore, Md. 21224.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.  |  | 19. DATE OF OPERATION   |  | 20a. AUTOPSY?   |  |
| IMMEDIATE CAUSE (a) SEPSIS-PNEUMONIA  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 0389  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.   |  | (b)   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |
| (c)   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 03-23-81, to 03-23-81, that (I) (we) lost<br>saw the deceased alive on 03-23-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>DEGREE  |  | 22c. DATE SIGNED  |  |
| DR. W.A. IMPAGLIATELLI M.D.   |  |   |  | 3/23/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 22f. REGISTRAR'S SIGNATURE  |  |
|   |  | CHURCH HOSPITAL CORPORATION 21231<br>100 N. BROADWAY BALTIMORE, MARYLAND XXXX                             |  | MAR 26 1981   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 3/26/81   |  | Woodlawn Cemetery   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24a. DATE REC'D. BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE  |  |
| John A. Moran, Inc.<br>3000 E. Baltimore St.<br>Baltimore Md. 21224   |  | MAR 26 1981   |  | [Signature]   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

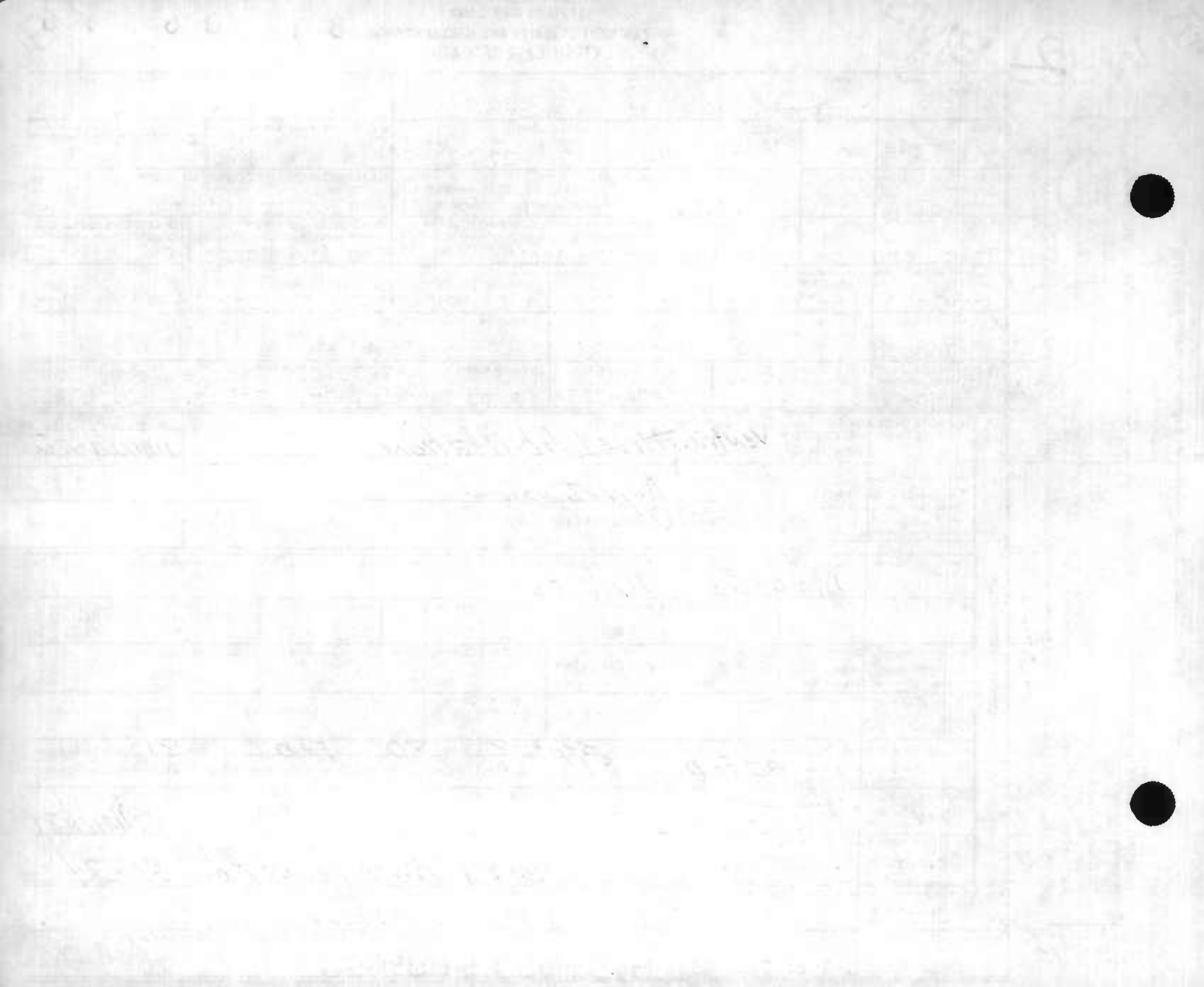
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 0 6 / 9 8   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| Czeslawa Budny  |  |   |  | March 4, 1981   |  |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |  |
| Female  |  | White   |  | 2 27 1896   |  | 85 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |  |
| Poland  |  | U.S.A.  |  |   |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| Baltimore   |  | Baltimore City Hospital's   |  | Packing House   |  | Crosse & Blackwell  |  |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Maryland  |  |   |  | Baltimore   |  | Dundalk   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |
| Joseph Jankowski  |  |   |  | Franceiszki   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |
| No  |  |   |  | 216-24-3054   |  | 7638 Old Battle Grove Road<br>James Durkin, Sr. Balto., MD. 21222 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |   |  |
| PART 1. DEATH WAS CAUSED BY: <u>Ventric Atrial Aibrillation</u>   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>4019</u>   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u>  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?    |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>Sept 8</u> , 19 <u>80</u> , to <u>Feb</u> , 19 <u>81</u> , that (i) (we) last saw the deceased alive on <u>26 Feb</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Dr. John B. Littleton</u>  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22d. DATE SIGNED<br><u>5 March 81</u>                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | 3/9/1981  |  | Holy Cross Pol. Nat. Dundalk  |  | Baltimore MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Duda-Ruck, Inc. 7922 Wise Ave. Dundalk, MD 21222  |  |   |  | MAR 6 1981  |  | <u>Anthony McBratney</u>  |  |

BP.





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROLAND FRANK BULL</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>3/10/81</b>                                    |  | 2b. HOUR <b>11:50</b> M   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4/23/07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md</b>  |  |   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Silas Bull</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Duval</b>                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218 10 4797A</b>   | 17. INFORMANT ADDRESS<br><b>Eunice Aquilano 217 Church Road Reisterstown</b>       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Adenocarcinoma Ascending colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>High out-put renal failure, Cardiac failure</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>2/12/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11/81</b> 19 <b>81</b> , to <b>3/10/81</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/10/81</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Dr. Anna Amundelcer</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>3/10/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARUNA ARWINDIEKAN</b>  |  | 22e. ADDRESS<br><b>Nath Charles general hospital</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/13/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Co. Md</b>   |
| 24. FUNERAL SERVICE<br>NAME ADDRESS<br><b>Burgee Funeral Home 3631 Falls Road 21211</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13

RECEIVED  
JAN 13 1961  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO: SAC, HONOLULU  
FROM: SAC, SAN FRANCISCO  
SUBJECT: [Illegible]

RE: [Illegible]  
[Illegible]

1-11-61  
[Illegible]

1-11-61  
[Illegible]

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                             | 8106300  |              |   |  |
|--|--|--|-----------------------------|--|--------------|---|--|
| 1. FOR STATE REGISTRAR   |  |  |                             | REG. NO.   |              |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>WILLIAM T. BULLETT  |  |  | 2a DATE OF DEATH<br>3 19 81 |  | 2b HOUR<br>M |   |  |
| 3 SEX<br>M   |  | 4 RACE<br>B  |                             | 5 DATE OF BIRTH<br>8 12 28   |              | 6 AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. VA  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |                             | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>934 N. CHAPEL ST                           |                             | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LABORER  |              | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD.  |  |  |                             | 13b COUNTY<br>BALTO.   |              | 13c STREET ADDRESS<br>934 N. CHAPEL ST.   |  |
| 14 FATHER'S NAME<br>STANLEY  |  | 15 MOTHER'S MAIDEN NAME<br>Edith GRAVES  |                             |  |              |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>232-40-9898   |                             | 17 INFORMANT ADDRESS<br>Donald Hamilton 1907 E. EAGER ST.  |              |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 4960 (Unknown) - possible Acute Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Obstructive Lung Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Smoking, Inactive TBC<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                             |  |              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |                             |  |              |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |              | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |              |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                             | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |              |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 1980 to 1981, that (I) (we) last saw the deceased alive on March 2, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |                             |  |              |   |  |
| 22b SIGNATURE<br>J. Ellis Stow   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                             | 22c. DATE SIGNED<br>3/24/81  |              |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Ellis Stow  |  | 22e ADDRESS<br>Provisional Hospital, Balt MD.  |                             |  |              |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b DATE<br>3/26/81  |                             | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.   |              | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.   |  |
| 24 FUNERAL DIRECTOR NAME<br>HEROY HARRIS FLS   |  | ADDRESS<br>4520 Pen Lucy Rd.   |                             | 25a DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |              | 25b REGISTRAR'S SIGNATURE   |  |



DALLAS  
TEXAS

2nd  
Floor

NO  
10

334 N. CHASE ST  
DALLAS

2nd  
Floor

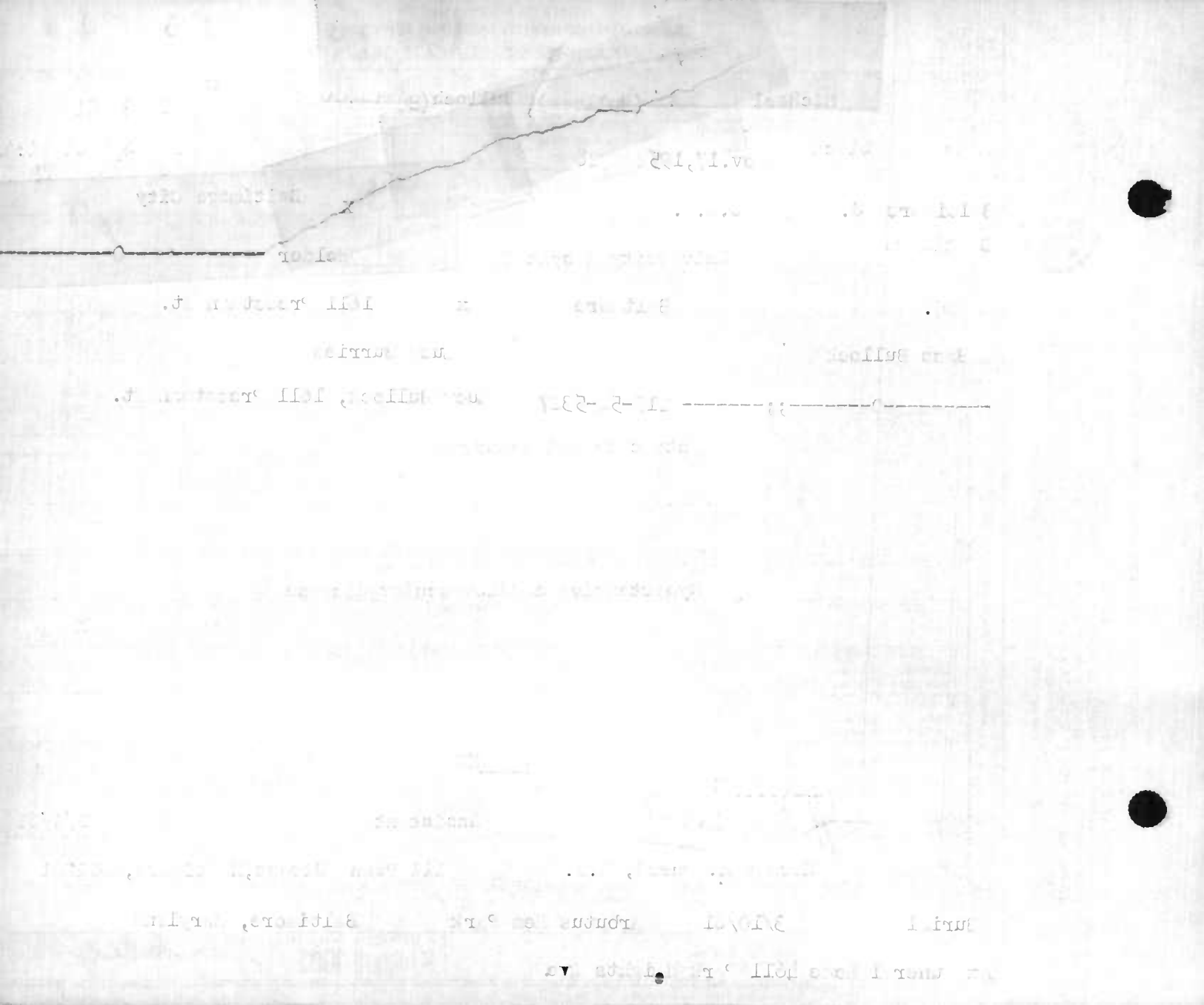
NO  
10

DALLAS  
TEXAS

2nd  
Floor

NO  
10





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 777-3383.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 0 2  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HATTIE</b> <b>NMI</b> <b>BURDEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-14-81</b>                  |  | 2b. HOUR<br><b>5:32 AM</b>   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b>                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 27 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MARYLAND HOSPITAL</b>              |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALT</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Menien Higgins</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAGGIE NMI LEE</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-12-7327</b>   |  | 17. INFORMANT ADDRESS<br><b>James W. Burden 4028 Fairfax Rd.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO/PULMONARY ARREST</b><br><b>1836</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OVARIAN CA STAGE III</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b>  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos</b><br><b>2 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>MARCH 7</b> , 19 <b>81</b> , to <b>MARCH 14</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>MARCH 14</b> , 19 <b>81</b> , and that in <b>my</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><b>H.W. Sundermier MD</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>3/14/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUNDERMIER</b>   |  | 22e. ADDRESS<br><b>UNIV. OF MARYLAND HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/19/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 17 1981</b> <b>[Signature]</b>   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MANTIA</b> FIRST <b>MANTIA</b> MIDDLE <b>BURGIDA</b> LAST |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-31-81</b> |   |  | 2b. HOUR<br><b>330A</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 25 1887</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HUNGARY</b>                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> CITY MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |   |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)          |  |   |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WOLF ROTH</b>                                       |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RIFKA UNKNOWN</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>073-42-0137</b>   |  | 17. INFORMANT <b>MR. HERMAN ROTH</b><br><b>4000 ROSECREST AVE. BALTO., MD 21215</b>   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 wks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**ORGANIC BRAIN SYNDROME**

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> , 19 <b>75</b> , to <b>3/31</b> , 19 <b>81</b> , that (I) (we) last<br>saw the deceased alive on <b>3/31</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3/31/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>130 ZAW-WIN</b>  |  | 22e. ADDRESS<br><b>LEVINDALE HEBREW HOME</b>  |  |  |  |   |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>            |  | 23b. DATE<br><b>3/31/81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHOMREI MISHMERES SCHAR'S</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1981</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                        |  |
| 6010 REISTERSTOWN RD. BALTO. MD 21215                                 |  |                             |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |                            |   |  |   |   |  | 8 1 0 6 8 0 4   |  |
|--|--|--|--|----------------------------|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |                            |   |  |   |   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |                            | 2a. DATE OF DEATH   |  |   |   |  | 7b. HOUR  |  |
| FIRST MIDDLE LAST<br>ZELDA M. BURKNER  |  |  |  |                            | MONTH DAY YEAR<br>March 18 1981   |  |   |   |  | 7 P M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH           |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR  |   |  |
| Female   |  | Black  |  | MONTH DAY YEAR<br>01 24 21 |   |  | 59 YRS.   |   | MONTHS DAYS HOURS MIN.   |   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH      |  |   |  |
| Baltimore, Md.   |  | U.S.A.   |  |                            |   |  |   | Baltimore City MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                            |   |  |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| Baltimore  |  | University of Maryland Hospital  |  |                            |   |  |   |   |  | Worster Center  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN          |   | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS                       |  |   |  |
| MD.  |  |  |  | BALTIMORE                  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 2920 RIGGS AVE. 21216                     |  |   |  |
| 14. FATHER'S NAME  |  |  |  |                            | 15. MOTHER'S MAIDEN NAME  |  |   |   |  |   |  |
| FIRST MIDDLE LAST<br>JOHN GREEN  |  |  |  |                            | FIRST MIDDLE LAST<br>MARTHA GILLISON  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |                            | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |   |  |   |  |
|  |  |  |  |                            | 220 12 7396   |  | Kerri T. Elliott 2920 Riggs Ave                                     |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:  |  |  |  |                            |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| IMMEDIATE CAUSE (a) <u>pericardial tamponade</u>   |  |  |  |                            |   |  |   |   |  | 18 hours  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>probable pericardial metastasis</u>   |  |  |  |                            |   |  |   |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>lung vs. colon carcinoma (probably former)</u>  |  |  |  |                            |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>colon carcinoma acute upper GI bleeding</u>   |  |  |  |                            |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                            |   |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |  |                            |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                            |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
|  |  |  |  |                            |   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
|  |  |  |  |                            |   |  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>81</u> , to <u>March 18</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |                            |   |  |   |   |  |   |  |
| 22b. SIGNATURE   |  |  |  |                            | DEGREE  |  |   |   |  | 22c. DATE SIGNED  |  |
| Dr. Marlene F. J. Ro   |  |  |  |                            |   |  |   |   |  | 3/18/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |                            | 22e. ADDRESS  |  |   |   |  |   |  |
| DR. Marlene F. J. Ro for Dr. R. J. J. I  |  |  |  |                            | Univ. of Md. Hospital   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |                            | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION                             |  |   |  |
| Burial   |  |  | 3/23/81  |                            | Mt Auburn Cem   |  |   | Baltimore CITY OR TOWN COUNTY STATE<br>Md |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |  |  |                            | 25a. DATE REC'D. BY REGISTRAR   |  |   | 25b. REGISTRAR'S SIGNATURE                |  |   |  |
| William C. March F/H 1101 E. North Ave   |  |  |  |                            | MAR 20 1981   |  |   |   |  |   |  |

1861 0.8 9AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 0 5

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>XXXXXX</del> <del>MORONNY</del> <b>Amelia D. BURNS</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-31-81</b>   |  | 2b. HOUR<br><b>6:30AM</b>   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home and Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton Triboll</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte Kuhl</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>102-07-0128</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md. 21226</b><br><b>Mr. William Isaac 1503 Filbert Street</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>WITH GLOBAL CEREBROVASCULAR ACCIDENT</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>3-26</b> , 19 <b>81</b> , to <b>3-31</b> , 19 <b>81</b> , that (1) we last saw the deceased alive on <b>3-31</b> , 19 <b>81</b> , and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.                           |  |   |  |   |  |
| 22b. SIGNATURE<br><b>William H. Williams, MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-31-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. W. H. WILLIAMS, MD</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b><br><b>100 N. BROADWAY BALTIMORE, MD. 21231</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>4/2/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mc Cully Funeral Home of Curtis</b><br><b>4200 Pennington Avenue Baltimore, Md. 21226</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION



*Handwritten signature or mark*

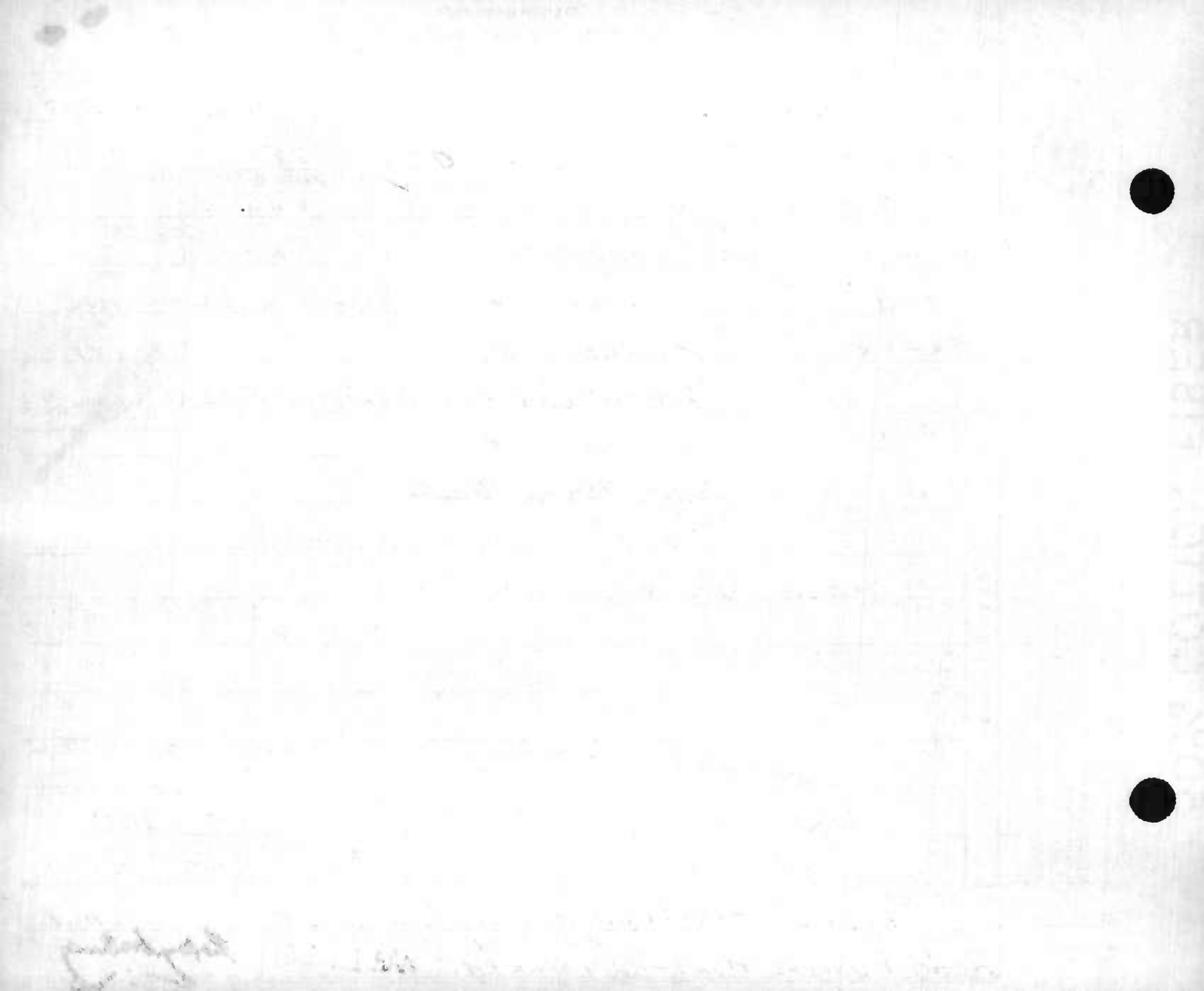
1821 8 14A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 0 6 8 0 5   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIE A. BURRS</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 10 1981</b>  |  |   |   |
| 3. SEX<br><b>FEMALE</b>   |  |   |  | 2b. HOUR<br><b>2:40 P.M.</b>  |  |   |   |
| 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 17 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |
| 13a. STATE<br><b>md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK BURRS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA Smith</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-8200</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MARY DICKERSON 523 WILLOW AVE</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio/Respiratory Arrest</b><br><b>7070</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis, <del>Septicemia</del> <del>Disseminated</del></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Extensive Decubitus Ulcers, infected</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Seizure Disorder, Diabetes Mellitus</b>   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 28</b> 19 <b>81</b> , to <b>March 10</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 10</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Douglas Adenlaur</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/10/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Douglas Adenlaur</b>  |  | 22e. ADDRESS<br><b>40 Union Memorial Hosp. Balt., Md.</b>   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-14-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEMET. BALTO.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Redd Funeral Home-5209 YORK Rd.</b>  |  | ADDRESS<br><b>BALTO. MD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |





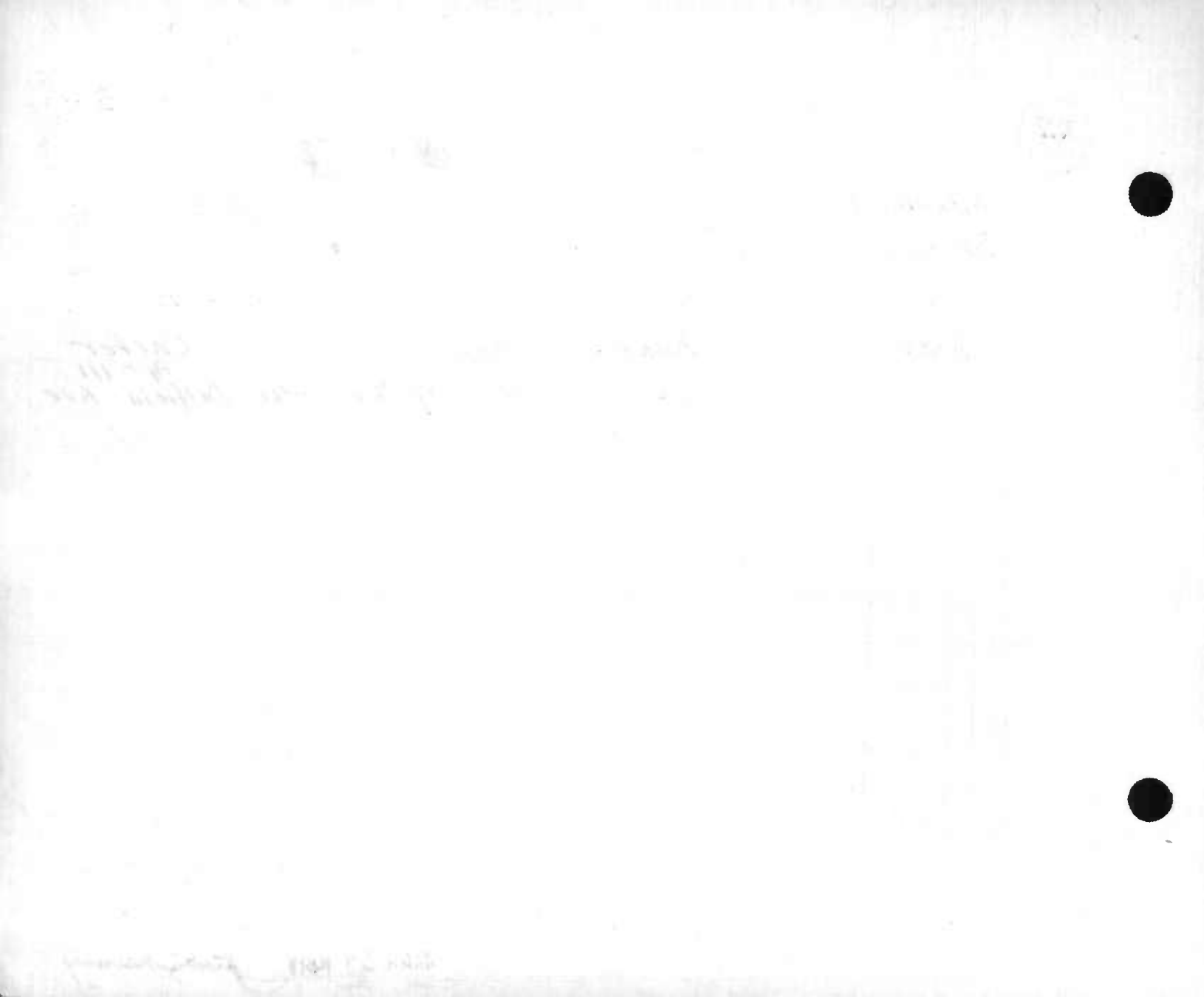
5

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |   |   |   | 8  | 1                           | 0   | 6                                 | 8   | 0 | 7 |
|--|--|--|--|--|---|---|---|---|---|--|-----------------------------|---|-----------------------------------|---|---|---|
| 1. FOR STATE REGISTRAR   |  |  |  |  |   |   |   |   |   | REG. NO.   |                             |   |                                   |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>GEORGE</b>  |  |  |  |  | FIRST MIDDLE LAST<br><b>BURTON</b>                              |   |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 19 81</b>   |                             |   | 2b. HOUR<br><b>5:45 PM</b>        |   |   |   |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 29 08</b>               |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>                              |   |  | IF UNDER 1 YEAR MONTHS DAYS |   | IF UNDER 24 HRS HOURS MIN.        |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |                             |   |                                   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTIMORE</b> |  |   |   |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>7</b>  |                             |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                           |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3800 BELVEDERE AVE.</b>                 |  |                             |   |                                   |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jesse</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ada Carter</b> |   |   |   |   |  |                             |   |                                   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-1460</b>                  |   |   | 17. INFORMANT ADDRESS<br><b>Janice Spiller Apt 111 3406 Delfield Ave</b>  |   |  |                             |   |                                   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral CVA</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>ASC D</b><br>(c) <b>ASC D</b>   |  |  |  |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>  |                             |   |                                   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |   |   |   |   |  |                             |   |                                   |   |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                             |   |                                   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |                             |   |                                   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |                             |   |                                   |   |   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>3/19/81</b> 19 <b>81</b> , to <b>3/19</b> 19 <b>81</b> , that (we) last saw the deceased alive on <b>3/19</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. |  |  |  |  |   |   |   |   |   |  |                             |   |                                   |   |   |   |
| 22b. SIGNATURE OF DEGREE<br><b>Kenneth M. Zonies MD</b>  |  |  |  |  |   |   |   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                             | 22c. DATE SIGNED<br><b>3/19/81</b>                  |                                   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth M. Zonies</b>  |  |  |  |  |   |   |   |   |   | 22e. ADDRESS<br><b>10807 Falls Rd Lutherville</b>  |                             |   |                                   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>3/24/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balt Nat. Cem.</b>     |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>            |   |  |                             |   |                                   |   |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>WM.C. MARCH F/H INC.</b>   |  |  |  |  |   |   |   |   |   | ADDRESS<br><b>1101 E. North Ave.</b>   |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b> |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Maloney</b> |   |   |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 0 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN A BUTLER</b>          |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03 26 81</b> |  |  | 2b. HOUR<br><b>230P</b> M  |  |  |  |
| 3 SEX<br><b>male</b>  |  | 4 RACE<br><b>BLACK</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>01 09 96</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Woodville Md.</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>                   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY        |  |

|   |  |                             |  |                                   |  |  |  |  |
|---|--|-----------------------------|--|-----------------------------------|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                                   |  | 13e. STREET ADDRESS<br><b>808 N. Fremont Ave.</b>                              |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b> |  | 13c. CITY OR TOWN<br><b>BALTO</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN BUTLER UNKNOWN</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN BUTLER</b>                          |  |                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWI</b> |                                   |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-18-528</b>   |  |                             | 17 INFORMANT ADDRESS<br><b>Marie Elliot, 18 N. Edgewood Blvd</b>   |                                   |  |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 0389<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | (b) <b>SEPSIS &amp; RENAL FAILURE</b>           |  |
| (c)  |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>2/18/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>BLEEDING GASTRIC ULCER.</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from **Feb 10** 19 **81**, to **March 26** 19 **81**, that (I) (we) lost  
saw the deceased alive on **March 26** 19 **81**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|  |  |  |  |                                     |  |
|--|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE<br><b>E J Doolin</b>                        |  | DEGREE   |  | 22c. DATE SIGNED<br><b>26 March</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E J Doolin</b> |  | 22e. ADDRESS<br><b>2250 Green St Baltimore</b> |  |                                     |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                    |  | 23b. DATE<br><b>3-30-81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NAT. CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. CO. MD.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph L. Russ 22226 North Ave.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1981</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                    |  |

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1981 10 23

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 8 0 9   |  |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |
| JAMES THOMAS BUTTON  |  |  |  | MONTH DAY YEAR  |  |
| 3. SEX   |  |  |  | 2b. HOUR  |  |
| MALE   |  |  |  | 3:30 A M  |  |
| 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| WHITE  |  | MONTH DAY YEAR   |  | 59 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| MARYLAND   |  | U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| BALTIMORE  |  | ST AGNES HOSPITAL  |  | ELECTRICAL SUPER* ELEC. CONTRS.   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  |
| MARYLAND   |  |  |  | ---   |  |
| 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |
| BALTIMORE  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |
| JAMES THOMAS BUTTON  |  |  |  | ETHEL MARIE BELT  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |
| YES WW II  |  |  |  | 220-03-2020   |  |
| 17. INFORMANT  |  |  |  | ADDRESS   |  |
| LIELA M. BUTTON  |  |  |  | 3913 WILKENS AVENUE, 21229  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Myocardial Infarction.   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (b)  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |
| (c)  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| Aspiration pneumonia - S/P Reuss -   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
|  |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |
|  |  |  |  | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2 19 81, to 3/14 19 81, that (I) (we) lost saw the deceased alive on 3/14 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED  |  |
| BICH T DUONG   |  |  |  | 8/14/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |
| BICH T DUONG   |  |  |  | 900 CATON AVENUE BALTIMORE MD 21229   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL   |  | 03-17-81   |  | LOUDON PARK   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE RECD BY REGISTER   |  | 25b. REGISTER   |  |
| HUBBARD FUNERAL HOME, INC.   |  | 21229  |  | MAR 16 1981   |  |

BALTIMORE CITY

BALTIMORE CITY

*[Handwritten signature]*

MAR 18 1931

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 1 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |   |  |   |  |
|---|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALFRED B. BYRD   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-2-1981                         |   |  | 2b. HOUR<br>7:10 P.M.  |   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 27, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hosp. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accoun. Clerk    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Md. St. Police  |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2930 Glenmore Ave. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Napoleon Byrd   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Harrison   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-34-1473A |   | 17. INFORMANT<br>ADDRESS<br>Mary L. Byrd, 2930 Glenmore Ave.                   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction.<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Myocardial infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |   |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2, 1981, to 3/2, 1981, that (I) (we) last saw the deceased alive on 3/2/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Suresh Tripathi MD  |  |   |   |   |  | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>3/2/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Suresh TRIPURANENI   |  |   |   |   |  | 22e. ADDRESS<br>Good SAMARITAN HOSPITAL  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>Mar. 3, 1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto., Md.                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>Rafael M. Brady  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



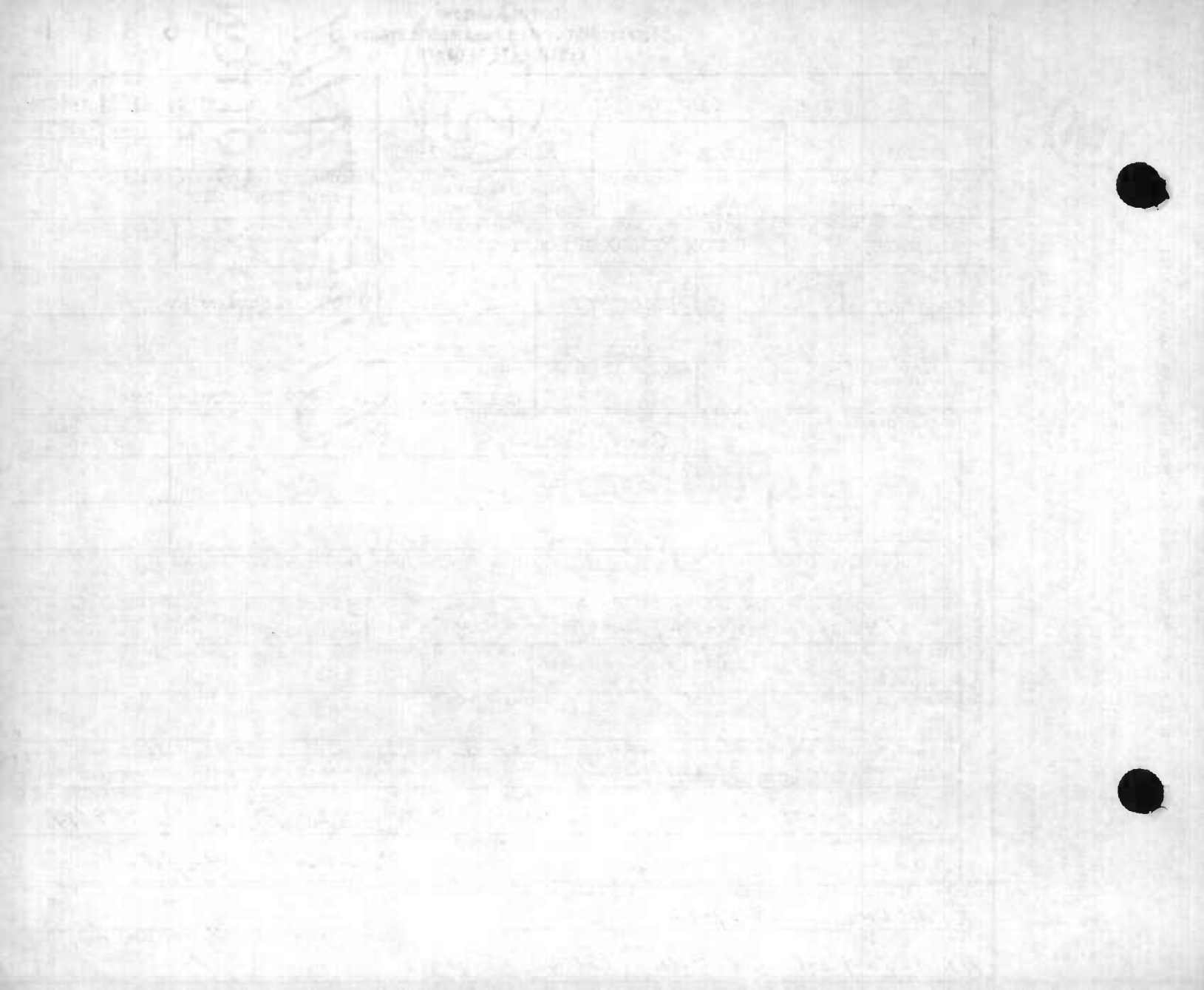


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |                          |   |   |   |   |  |  |  |
|--|--|---|--|--|--------------------------|---|---|---|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  | 8 1 0 6 8 1 1            |   |   |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  | REG. NO.                 |   |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH        |   |   |   |   | 2b. HOUR   |  |  |
| OMEGU TAMIKIA CABEZA   |  |   |  |  | MARCH 9, 81              |   |   |   |   | 3:40PM   |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                       |   | 7. IF UNDER 1 YEAR  |   | 7. IF UNDER 24 HRS   |  |  |
| FEMALE   |  | BLACK   |  | MARCH 9 1981   |                          | YRS.  |   | MONTHS  |   | DAYS   |  |  |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                  |   |   |   |  |  |  |
| MARYLAND   |  | U.S.A.  |  |  |                          | BALTIMORE CITY  |   |   |   | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |                          |   | 12a. USUAL OCCUPATION                   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| BALTIMORE  |  | UNION MEMORIAL HOSPITAL                                 |  |  |                          |   | (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |   |  |  |  |
| 13a. STATE   |  |   |  |  | 13b. COUNTY              |   | 13c. CITY OR TOWN                       |   | 13d. INSIDE CITY LIMITS?  |  |  |  |
| MARYLAND   |  |   |  |  |                          |   | BALTIMORE                               |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME  |  |   |  |  | 15. MOTHER'S MAIDEN NAME |   |   |   |   |  |  |  |
| PEDRO LORENZO CABEZA   |  |   |  |  | CELESTINE REED           |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT                           |   |   |  |  |  |
| NO   |  |   |  |  |                          |   | CELESTINE REED 1409 Cliftview Ave       |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |                          |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |  |
| PART I. DEATH WAS CAUSED BY  |  |   |  |  |                          |   |   |   |   | 2 minutes  |  |  |
| IMMEDIATE CAUSE (a) Cardiovascular collapse  |  |   |  |  |                          |   |   |   |   |  |  |  |
| 7620 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                          |   |   |   |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |                          |   |   |   |   |  |  |  |
| (b) Prematurity  |  |   |  |  |                          |   |   |   |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |                          |   |   |   |   |  |  |  |
| (c) Placenta Previa  |  |   |  |  |                          |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |                          |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 3/9/81   |  |   |  | Bleeding 20 Total Placenta Previa  |                          |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED                              |   |   |   |  |  |  |
|  |  |   |  | HOUR A.M. MONTH DAY YEAR   |                          | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |  |  |
|  |  |   |  | P.M. 19  |                          |   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED   |  |   |  | 21e. PLACE OF INJURY   |                          | 21f. LOCATION   |   |   |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                          | STREET CITY OR TOWN COUNTY STATE                      |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9/81 to 3/9/81, that (I) (we) lost saw the deceased alive on 3/9/81 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                          |   |   |   |   |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |                          |   |   | HOUSE   |   | 22c. DATE SIGNED   |  |  |
| Onkar Nath Singh   |  |   |  | MD.  |                          |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |   | 3/9/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |                          |   |   |   |   |  |  |  |
| ONKAR NATH SINGH   |  |   |  | Union Memorial Hospital  |                          |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY                    |   |   | 23d. LOCATION   |  |  |  |
| REMOVAL  |  |   |  | 3-19-81  |                          |   |   |   | CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |                          |   |   | 25b. REGISTRAR'S SIGNATURE  |   |  |  |  |
| ANATOMY BD. OF MD.   |  |   |  | BALT., MD  |                          |   |   |   |   |  |  |  |

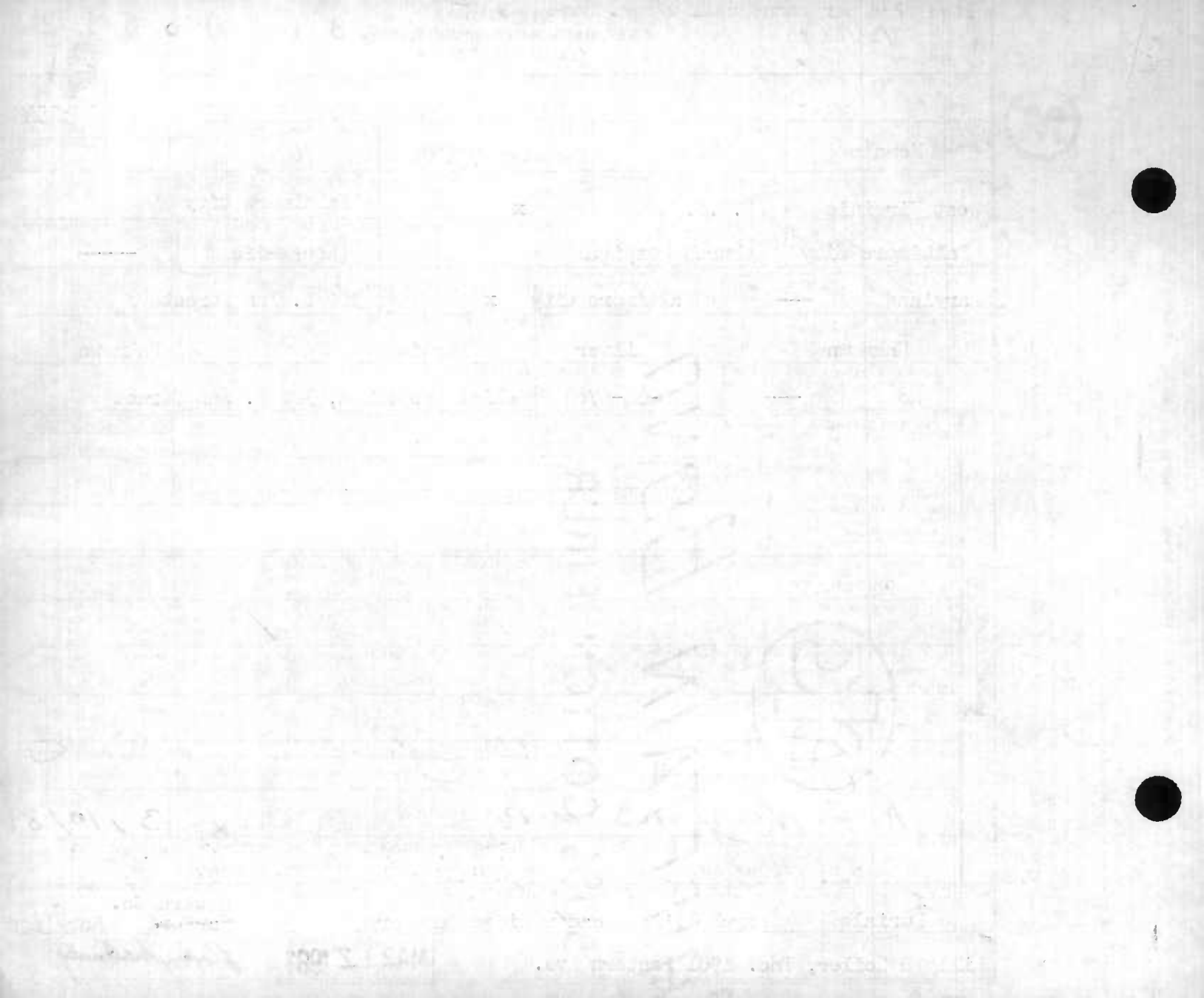


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |   |                                    |  |   |  |  |
|---|--|---|--|--|---|---|------------------------------------|--|---|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |   |   |                                    |  |   |  |  |
| REG. NO.  |  |   |  |  |   |   |                                    |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | 2a. DATE OF DEATH                                   |   |                                    |  |   |  |  |
| FIRST MIDDLE LAST<br><b>GOLDIE CALDWELL</b>   |  |   |  |  | MONTH DAY YEAR HOUR<br><b>MARCH 10 1981 10:35AM</b> |   |                                    |  |   |  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)  |                                    | 7 IF UNDER 1 YEAR  |   |  |  |
| Female  |  | White   |  | MONTH DAY YEAR<br><b>December 7 1904</b>   |   | 76 YRS.   |                                    | MONTHS DAYS HOURS MIN.   |   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH   |                                    |  |   |  |  |
| West Virginia   |  | U.S.A.  |  |  |   | Baltimore City MD.  |                                    |  |   |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                    | 12b KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| Baltimore City  |  | Church Hospital   |  |  |   | Housewife   |                                    |  |   |  |  |
| 13a. STATE  |  |   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland  |  |   |  |  | ---   |   | Baltimore City                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME  |  |   |  |  | 15. MOTHER'S MAIDEN NAME                            |   |                                    |  |   |  |  |
| FIRST MIDDLE LAST<br><b>Unknown Silver</b>  |  |   |  |  | FIRST MIDDLE LAST<br><b>Bertie Unknown</b>          |   |                                    |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  | 16b SOCIAL SECURITY NO.                             |   | 17 INFORMANT                       |  |   | ADDRESS  |  |
| no  |  |   |  |  | 220-14-6760   |   | Alice Gustafson, 306 S. Ann Street |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |   |   |                                    |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |   |   |                                    |  |   |  |  |
| IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b>   |  |   |  |  |   |   |                                    |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |   |   |                                    |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |   |   |                                    |  |   |  |  |
| (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |  |   |   |                                    |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |   |   |                                    |  |   |  |  |
| (c)   |  |   |  |  |   |   |                                    |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |   |   |                                    |  |   |  |  |
| <b>PNEUMONIA</b>  |  |   |  |  |   |   |                                    |  |   |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                    | 20a AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |   |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) |                                    |  |   |  |  |
|   |  |   |  |  |   |   |                                    |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                    |  |   |  |  |
|   |  |   |  |  |   |   |                                    |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> 19 <u>81</u> , to <u>3/10</u> 19 <u>81</u> , that (I) (we) (we) saw the deceased alive on <u>3/10</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death. |  |   |  |  |   |   |                                    |  |   |  |  |
| 22b. SIGNATURE  |  |   |  |  |   |   |                                    | DEGREE   |   | 22c. DATE SIGNED   |  |
| <b>A. F. Nazemi M.D.</b>  |  |   |  |  |   |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 3/10/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  |   |   |                                    | 22e. ADDRESS   |   |  |  |
| <b>A.F. NAZEMI, M.D.</b>  |  |   |  |  |   |   |                                    | <b>100 N. BROADWAY BALTIMORE, MD. 21231<br/>CHURCH HOSPITAL CORPORATION</b>  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |  |  |
| Burial  |  |   |  | March 13 '81   |   | Meadow Ridge Cemetery   |                                    | Howard Co. Maryland  |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  |   |  |  |   |   |                                    | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Lilly & Zeiler, Inc. 1901 Eastern Ave.  |  |   |  |  |   |   |                                    | MAR 12 1981  |   | <i>Lilly &amp; Zeiler</i>                                      |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 1 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John B Calvert</b>                         |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>3 16 81</b>                                   |   | 2b. HOUR <b>5<sup>30</sup> PM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-18-09</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.             |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                           | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO</b> <b>Co. City MD.</b>          |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>REALTOR</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>REAL EST.</b> |   |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>—</b>   | 13c. CITY OR TOWN<br><b>BALTO</b>                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                          |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |   | 16b. SOCIAL SECURITY NO.<br><b>217-01-7488</b>  | 17. INFORMANT<br>ADDRESS<br><b>SHIRLEY HAZARD - OCEAN CITY</b>                    |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Renal Failure**

**5996**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Obstructive Uropathy**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**~ 2 weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Pneumonia (Etiology uncertain)**

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/4</b> , 19 <b>81</b> , to <b>3/16</b> , 19 <b>81</b> that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Jeffrey Abrams</b>   | DEGREE<br><b>M.D.</b>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>3/16/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey Abrams</b>  |  | 22e. ADDRESS<br><b>900 Caton Ave - St Agnes Hosp - Balt. Md</b>  |  |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>3-19-81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET M.P.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BERLIN MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Willrich Funeral</b>       |                             | 25. DATE REC'D. BY REGISTRAR<br><b>APR 5 1981</b>        |  |
| ADDRESS<br><b>Reelin M.P.</b>                                 |                             | REGISTRAR'S SIGNATURE                                    |  |



UNIVERSITY OF MICHIGAN

NOT TO BE USED FOR OTHER PURPOSES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 1 4

| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |   |  |  |
|---|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HARRY WILMER CAMPBELL SR.  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 23 81<br>2b. HOUR<br>2:48 A.M.   |  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 24 15   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65<br>IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, Baltimore, Maryland 21218 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bethlehem Steel<br>12b. KIND OF BUSINESS OR INDUSTRY<br>Steel |  |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Alleghany  |  | 13c. CITY OR TOWN<br>Cumberland   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE CAMPBELL   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>-LULA - Laura Unknown  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 217-10-5989   |  | 17. INFORMANT<br>ADDRESS<br>VAMC Medical Records, Baltimore, Maryland 18  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5770 Massive bilateral Pulmonary Embolism 30 min<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Bronchopneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Pancreatitis with pseudocyst<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from March 16, 19 81, to March 23, 19 81, that (X) (we) lost saw the deceased alive on March 23, 19 81, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Kristen B. Paines MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/23/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kristen Paines   |  |  |  | 22e. ADDRESS<br>VAMC, Baltimore, Maryland 21218   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE IF 1)   |  | 23b. DATE<br>3/26/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rest Lawn Mem. Gardens  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland, Md.   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hafer Funeral Service, LaVale, Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |  |   | REG. NO. 06815   |  |
|--|--|----------------------|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Peggy H. Canby</b>   |  |                      |  |  |  |   |  |  |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 15 1981  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>April 21, 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61 YRS.</b>                                |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |   | 2b. DATE PRONOUNCED DEAD 3 16 1981   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2302 Pentland Drive</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Mt. Carm. Ch</b>                            |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. COUNTY <b>City</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS <b>2303 Pentland Drive</b>                                   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Milton Stitcher</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Myrtle B. Shaw</b>            |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>219-07-1311</b>  |  | 17. INFORMANT ADDRESS <b>David L. Canby, Ocean City, Maryland</b>             |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                |  |                      |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE                                       |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  | DATE SIGNED <b>3/17/81</b>                    |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                      |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>3-19-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>                |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard, Maryland</b>         |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>18 MAR 1981</b>                              |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



*Handwritten signature*

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8 JAN 1821

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 1 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |                            |  |  |                                    |  |  |   |
|---|---|----------------------------|--|--|------------------------------------|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |                            | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |  |   |
| FIRST MIDDLE LAST<br>ANNIE PAULINE CANNOLES   |   |                            | MONTH DAY YEAR<br>3-28-81  |  |                                    | 5:45 A.M.  |  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH           |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |                                    |  | IF UNDER 1 YEAR                            |   |
| FEMALE  | WHITE   | MONTH DAY YEAR<br>08 27 97 |  | 83 YRS.  |                                    |  | MONTHS DAYS HOURS MIN.                     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |                                    |  |  |   |
| MARYLAND  | U.S.A.  |                            | BALTIMORE CITY MD.   |  |                                    |  |  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY          |   |
| BALTIMORE   | ST. AGNES HOSPITAL  |                            |  | MAID   |                                    |  | SELF-EMPLOYED                              |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |                            | 13b. CITY OR TOWN  |  |                                    | 13c. STREET ADDRESS  |  |   |
| 13a. STATE  |   |                            | 13b. COUNTY  |  |                                    | 13c. STREET ADDRESS  |  |   |
| MARYLAND  |   |                            | ---  |  |                                    | BALTIMORE  |  |   |
| 14. FATHER'S NAME   |   |                            | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |  |   |
| FIRST MIDDLE LAST<br>RANDOLPH AFFELDT   |   |                            | FIRST MIDDLE LAST<br>PAULINE MILLER                                    |  |                                    |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |                            | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT  |  |   |
| NO  |   |                            | 218-36-6856  |  |                                    | N. TARRYTOWN, NEW YORK 10591   |  |   |
|   |   |                            |  |  |                                    | GORDON L. CANNOLES 182 WEBBER AVENUE   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   |                            |  |  |                                    |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| IMMEDIATE CAUSE (a) <u>Severe stroke</u>  |   |                            |  |  |                                    |  |  | about 3 days  |
| 2500 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes Mellitus, ASCVD</u>  |   |                            |  |  |                                    |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHF</u>  |   |                            |  |  |                                    |  |  | 10 days   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |                            |  |  |                                    |  |  |   |
| 19a. DATE OF OPERATION  |   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
|   |   |                            |  |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   |                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 18, 1981</u> to <u>March 28, 1981</u> , that (I) (we) last saw the deceased alive on <u>March 3/23, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |                            |  |  |                                    |  |  |   |
| 22b. SIGNATURE<br><u>Victor Jaworsky</u>  |   |                            |  |  |                                    | DEGREE   |  | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Victor Jaworsky  |   |                            |  |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 3/28/1981   |
| 22e. ADDRESS<br>900 Caton Avenue Baltimore, MD  |   |                            |  |  |                                    |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |                            | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |
| BURIAL  |   |                            | 03-31-81   |  | LOUDON PARK                        |  | BALTIMORE CITY MARYLAND                    |   |
| 24. FUNERAL DIRECTOR<br>NAME  |   |                            | 24b. ADDRESS   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |
| HUBBARD FUNERAL HOME, INC.  |   |                            | 4107 WILKENS AVE.  |  |                                    | APR 1 1981   |  | <u>Victor Jaworsky</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

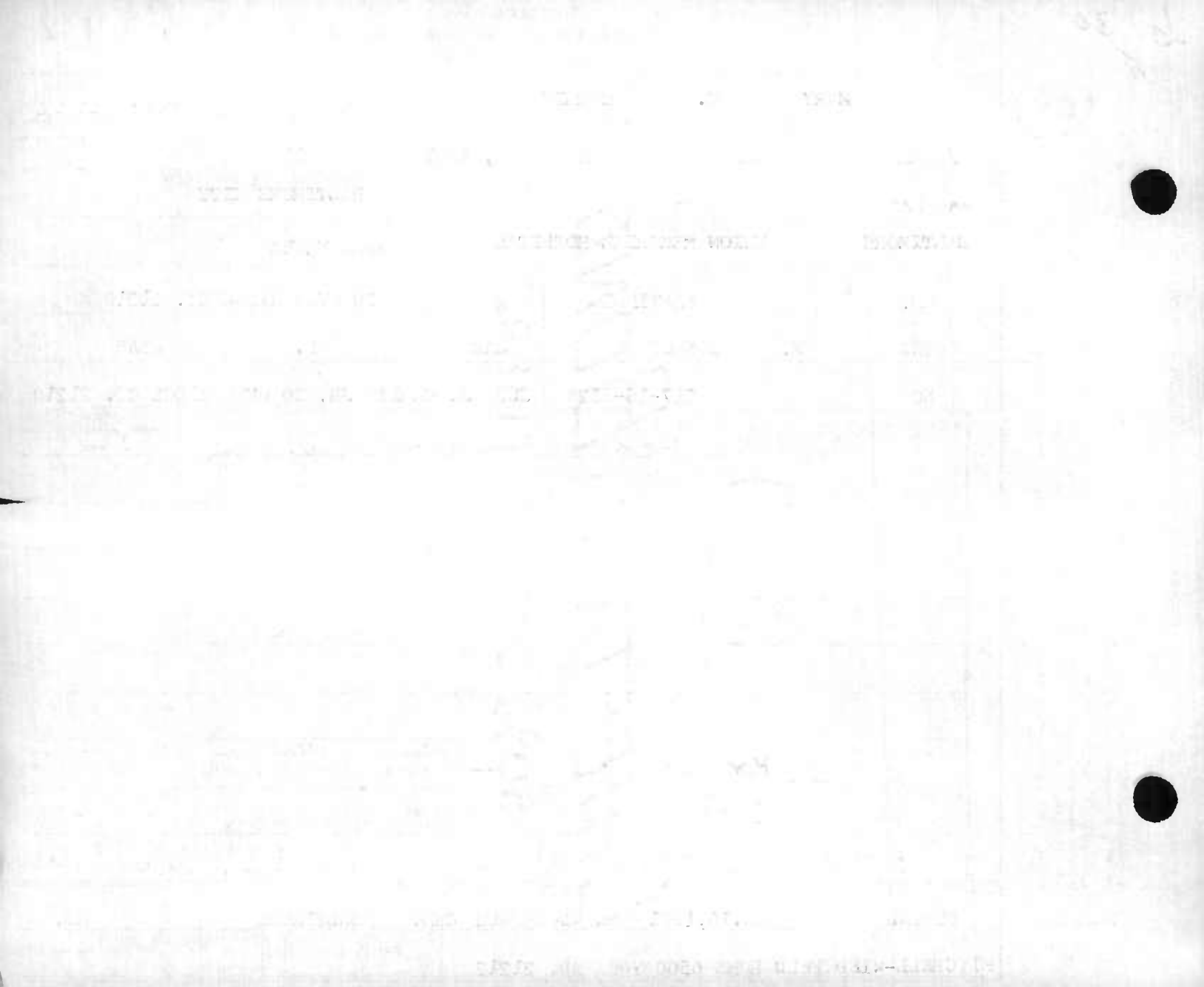
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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MARY C. CARLIN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>13</b> YEAR <b>1981</b> |   |  | 2b. HOUR<br><b>12:25 AM</b>   |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>APRIL</b> DAY <b>20</b> YEAR <b>1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOME MAKER</b> |  |  |
| 13a. STATE<br><b>MD.</b>  |  |   |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>PETER</b> MIDDLE <b>F.</b> LAST <b>CONROY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>L.</b> LAST <b>RYAN</b>           |  | 13d. STREET ADDRESS<br><b>30 OVER RIDGE CT. 21210</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-5528</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOHN J. CARLIN JR. 30 OVER RIDGE CT. 21210</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic anaplastic carcinoma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2mo</b> |  |   |  |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that <del>if</del> (this hospital) attended the deceased from <b>Feb 8</b> , 19 <b>81</b> , to <b>Mar 13</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>Mar 13</b> , 19 <b>81</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>that (we) did not</del> view the body after death.  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Rhoads Stevens MD</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3-13-81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RHOADS STEVENS MD</b>   |  | 22e. ADDRESS<br><b>201 E. Univ. Avey Balto 21218</b>                                      |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAR. 16, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 18 1981</b>  |  |   |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 8106818   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony Tony T. Carlotta</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 24, 1981</b>  |  | 2b. HOUR<br><b>912P<sup>M</sup></b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 24, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4601 Elsrode Avenue</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Owner-Home Improvements</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Pietor Carlotta</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Geatana Ditermino</b>   |  | 13e. STREET ADDRESS<br><b>4601 Elsrode Avenue</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 2</b>  |  | 17. INFORMANT<br><b>Mrs. Agnes O. Carlotta</b>  |  | ADDRESS<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Lung Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Swaden</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/1/18</b> 19 <b>81</b> to <b>3/23</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>1/20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.               |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert Fisher</b>   |  | DEGREE<br><b>MD.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/25/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Fisher MD.</b>  |  | 22e. ADDRESS<br><b>Fuller Medical Center Baltimore, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 28, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

1917

IN SENATE  
JANUARY 11, 1917  
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1916

ALBANY: J.B. LEECH, STATE PRINTER  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>1- STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 8 1 9  |                                   |   |  |
|---|--|--|--|---|--|--|--|--|-----------------------------------|---|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |  |                                   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ellen L. Carlton   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 16, 1981   |  |  |  | 2b. HOUR<br>8:45a <sub>M</sub>   |                                   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 27 12   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Ardleigh Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br>441 Oxford Ct.  |                                   |   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Skinner  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Helen Caulk  |  |  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Ernest Carlton 441 Oxford Court                       |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Liver Failure</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Cirrhosis of Liver</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u></u>  |  |  |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>weeks<br>years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |   |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 6, 1981</u> , to <u>2-16, 1981</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-16, 1981</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>have</u> (did not) view the body after death. |  |  |  |   |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br><u>L. Kemper Owens</u>  |  |  |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>L. Kemper Owens</u>   |  |  |  | 22e. ADDRESS<br><u>300 Army Place Balto, Md 21201</u>   |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  |  | 23b. DATE<br>3/20/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cem                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., MD.                  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/ H 1101 E. North Ave.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. H. H.</u>                                 |                                   |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |   |   |   |   |  |
|--|------------------|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Alton Carney  |                  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>3 30 19 81 |   |   | 2b. HOUR<br>M<br>2:56 P   |   |  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 23 04   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS.              | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>3 30 19 81  | 2d. HOUR<br>M<br>2:56 P   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital-DOA |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY           |  |
| 13a. STATE<br>MD   |                  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1223 N. Caroline St. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>214-18-9235   |   | 17. INFORMANT ADDRESS<br>Anthony Braxton 235 Bethel Ct.                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>  |                  |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   |   | DATE SIGNED <u>3-31-81</u>                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>   |                  |  |  | ADDRESS <u>111 Penn Street</u>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>4/6/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Wm. C. March F/H</u> ADDRESS <u>1101 E. North Ave.</u>   |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 03 1981  |   | 25b. REGISTRAR'S SIGNATURE <u>Anthony Braxton</u>                                   |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8106821   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>HELEN M. CARROLL   |  |  |  | 2b. HOUR 9:10 A  |  |   |  |
| 3 SEX FEMALE  |  | 4 RACE WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>09 19 16   |  | 6 AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  | 7c. CITIZEN OF WHAT COUNTRY? U S A   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH CITY MD   |  |
| 10 CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY Koppers Co.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE MARYLAND 13c. COUNTY Balto 13d. CITY OR TOWN Catonsville   |  |  |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JOHN P. HOUSLEY   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CATHERINE M. HIGGINS  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  | 16b. SOCIAL SECURITY NO 217-22-1911  |  | 17 INFORMANT Catonsville, Md. 21228<br>Mr. Charles E. Carroll, 2 Winstead Court  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENO-CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>RUDENBURG TUMOR</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION 1/11/81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTESITINAL Obstruction</u>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from 3/26/81 19 81 to 3/31 19 81, that (I) (we) last saw the deceased alive on 3/31 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22a. SIGNATURE <u>Stephen K. Padurus MD</u> DEGREE <u>MD</u>  |  |  |  | 22b. DATE SIGNED 3-31-81   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN K. PADURUS MD   |  |  |  | 22e. ADDRESS ST. AGNES MEDICAL CTR 21229   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 4/3/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A., Md  |  |
| 24 FUNERAL DIRECTOR 1630 Edmondson Ave. Catonsville, Md<br>Witzke Funeral Home of Catonsville, P.A. 21228   |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 2 1981   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |



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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 6 8 2 2   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANNIE CARTER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 14, 1981</b>   |  | 2b. HOUR<br><b>09:25 PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2/4/1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>85</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bkth.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |  | 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Bkth.</b>   |  | 13c. CITY OR TOWN<br><b>Bkth.</b>   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2220 Brookfield Ave</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Michael Diviss</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Josephine</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>712-12-7069</b>  |  | 17. INFORMANT<br><b>John Diviss</b>   |  | ADDRESS<br><b>2431 Gw. 1 St. Bkth. Ave</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyperventilation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous cell ca</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>1 yr.</b><br><b>&gt; 1 yr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>STREET</b>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/9/81</b> , 19 <b>81</b> , to <b>3/14/81</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>May Hoee</b>   |  |   |  | DEGREE<br><b></b>   |  | 22c. DATE SIGNED<br><b>3/14/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY HOTCHKISS</b>  |  |   |  | 22e. ADDRESS<br><b>601 N. BROADWAY</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>3/20/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary C.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>AA County MD</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Frank</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry H. H. H.</b>   |  |

DHMH-16 30M 2/80  
(VRA 15, 4)





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Nannie Virginia Carter  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 11 81   |  |  |  |
| X 1. SEX<br>FEMALE   |  |   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 5 98  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HAWK MARKER AT HOME  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2001 N. PULASKI ST.<br>1406 S. Lafayette Ave.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Johnson  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>215-24-392  |  | 17. INFORMANT ADDRESS<br>Louis A. Carter 4135 Forest Park Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>7070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>decubitus ulcer, pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>flu</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>S. Subana  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. SUBANA GOOL  |  |   |  | 22e. ADDRESS<br>Lutheran Hospital Baltimore MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/17/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD 21205  |  |
| 24. FUNERAL DIRECTOR<br>P. Hayes 635 N. Gilman St  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



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Handwritten notes or signatures at the bottom right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 06824

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |   |   |
|---|--|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROMAN H CARTER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 3 81 |   |   | 2b. HOUR<br>6:48 PM   |   |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 - 28 - 23   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSP |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTO  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO<br>217-16-0978  |   | 17. INFORMANT<br>EMILY R. CARTER  |   |   |   |
| 16c. ADDRESS<br>SAME  |  |   |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>2859 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Anemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) R/O pmtb Ca. of Lung  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2/81, 19, to 3/3/81, 19, that (I) (we) lost<br>saw the deceased alive on 3/3/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br>Nigel E.R. Jackman M.D.   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Nigel E.R. Jackman M.D.  |  |   |   | 22e. ADDRESS<br>Provident Hosp. 2600, Liberty Heights Ave<br>Baltimore Md.  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3/6/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem PK   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>VERNON BALIEV   |  |   |   | ADDRESS<br>1348 CALHOUN ST  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1981   |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |   |   |



*[Handwritten signature]*

MAR 2 1981

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO.   |   |  |  |
|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | 7 1 0 6 8 2 5  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RACHEL A. Casey.</b>   |  |   | 2r. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/24/81</b>   |  | 2b. HOUR<br><b>M</b>  |  |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>C 05 02</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Securus Hospital</b> |   | 12r. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13r. STREET ADDRESS<br><b>1327 Edmondson Ave.</b>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Berry Anderson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachel A.</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>249-28-6498</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MARY Thomas 1327 Edmondson Ave.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CVA - Bilateral</b><br><b>2449</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocardia Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF <b>Angina</b><br>(b) (c) |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21r. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> , 19 <b>81</b> , to <b>3/24</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/24</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Rolando A. Sabunogan</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/24/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rolando A. Sabunogan</b>  |  |   |   | 22e. ADDRESS<br><b>Bon Securus Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>3/30/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cem</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WM. C. MARCH F/H INC. 1101</b> ADDRESS <b>E. North Ave</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McBrady</b>  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |  |  | REG. NO. 06826  |  |
|--|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                      |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Eugene Casey</b>   |  |                      |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 13 81</b> |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 17 22</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>58</b>                             |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>3 13 81</b> 2d. HOUR <b>7:00</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                      |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>   |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1830 Walbrook Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Ben Casey</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Susan Frazier</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>248-32-7746</b>  |  | 17. INFORMANT ADDRESS <b>Barbara Casey 3512 Spaulding Ave.</b>                |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |  |                      |  | TITLE (SPECIFY) <b>ASSISTANT</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>3/14/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>HORMEZ R. GUARD, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>3/19/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b>   |  |                      |  | ADDRESS <b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1981</b>                              |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

7

WILLIAMSON CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

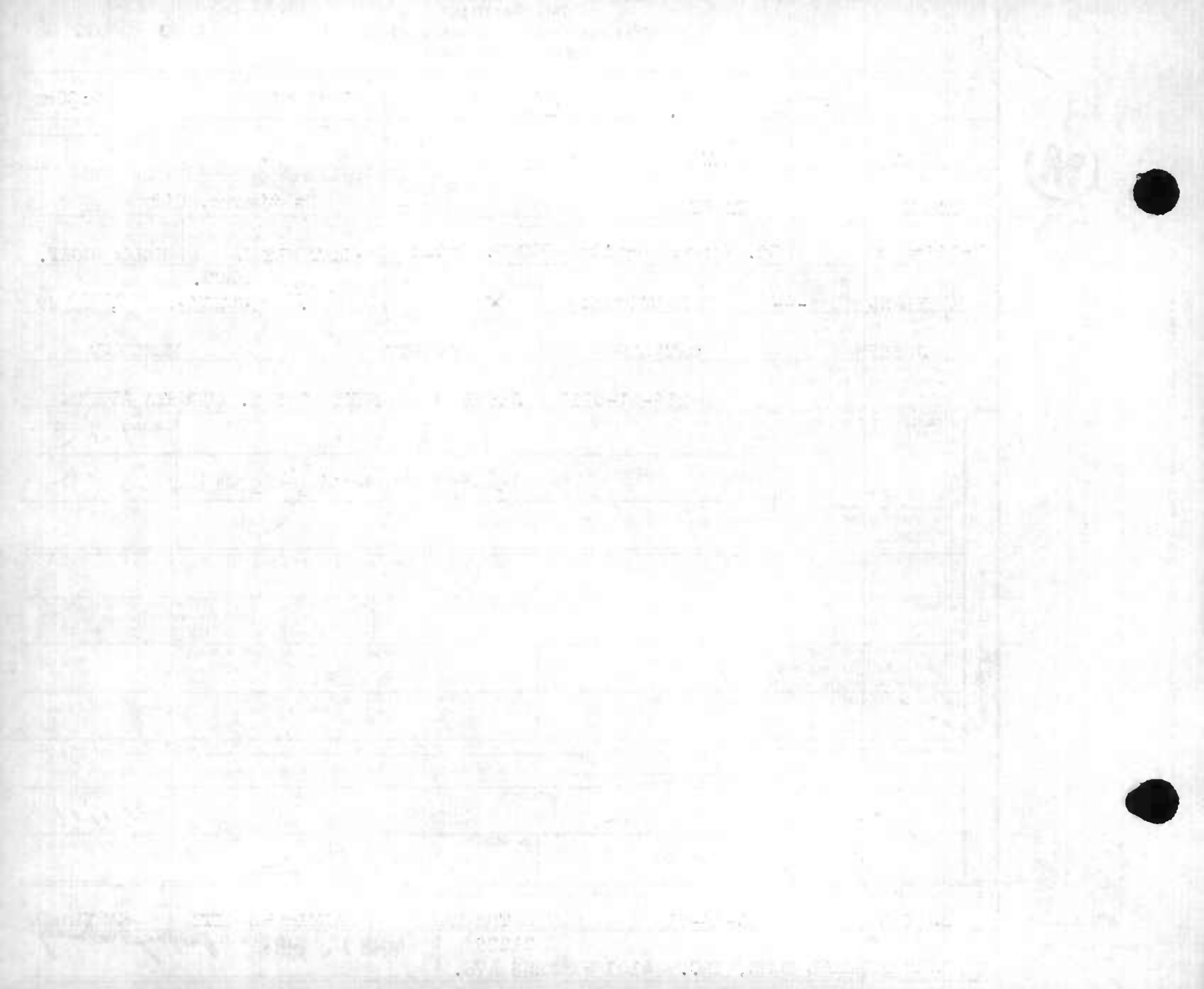
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |  |  |
|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SAMUEL C. CATALANO</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-12-81</b>                                  |   | 2b. HOUR<br><b>2:30am</b>  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08-25-04</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>ITALY</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.                     |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital-900 S. Caton</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SHEET METAL</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>KELCO CORP.</b>   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>MECH. 208 S. AUGUSTA AVENUE, 21229</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH CATALANO</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VENNERA MENCOSA</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-01-0717</b>  |  | 17. INFORMANT ADDRESS<br><b>JESSIE CHEARNEYI 208 S. AUGUSTA AVENUE</b>                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Just Fall</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>6WK</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>77K</b> |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>3/11</b> , 19 <b>81</b> , to <b>3/9</b> , 19 <b>81</b> , that (b) (we) last saw the deceased alive on <b>3/9</b> , 19 <b>81</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did/did not) view the body after death.  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Ray Bahr</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>3/12/81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAY BAH R</b>   |   | 22e. ADDRESS<br><b>St Agnes</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>03-16-81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>MAR 15 1981</b>   |  |  |



Item 6 g554 4/9/81 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 2 8

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAWRENCE E CAUSION</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 28, 1981</b>                                    |  | 2b. HOUR<br><b>10:04 PM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 8 42</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laborer</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |
| 13a. STATE<br><b>MD</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1114 Forest St</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LAWRENCE E. CAUSION</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CARRIE Foote</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-42-9402</b>   |  | 17. INFORMANT<br><b>Mrs. Carrie Causion</b>   |   |  |  |
| 16c. ADDRESS<br><b>1114 Forest St 21202</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiogenic shock</b><br><b>4253</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>alcoholic cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>10 years</b>   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>pulmonary emboli</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>81</b> , to <b>3/28</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |   |  |  |
| 21a. SIGNATURE<br><b>Mark J. Ratain</b>  |  | DEGREE<br><b>M.D.</b>   |   | 21c. DATE SIGNED<br><b>3/28/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK J. RATAIN</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>4/3/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stevenson AME Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sparks Balto. Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chotman F/H</b>   |  | ADDRESS<br><b>1201 Mc Cullagh St</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 31 1981</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia A. Brady</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral director's pages 1 and 2 and place them in the death certificate envelope.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 3 2 9

REG. NO.

|  |  |  |  |   |  |   |   |  |   |  |
|--|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Stanley John Cephalis</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 20, 1981</b>           |   |  | 2b. HOUR<br><b>6 A</b> M  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 24, 1933</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>519 N. Potomac St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Restor of Equip.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>West Electric</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Balto, Md.<br/>519 N. Potomac St, 21205</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Cephalis</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine Davis Czuba</b>                        |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>1955-1957 214-30-5436</b>               |   | 17. INFORMANT<br>ADDRESS <b>Balto, Md. 21205</b><br><b>Mrs. Rose Mary Cephalis-519 N. Potomac St</b> |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Ca. lung metastasis</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>C-a. lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION _____   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____                 |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>E. R. Anderson MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>3/21/81</b>  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. R. Anderson</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>8 E Eager St</b>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/23/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Md.</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Schimanek Funeral Home, 3331 Brehms La</b>  |  |  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 24 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 335-1333.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 3 0

4  
1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |                         |  |  |   |                                   |
|--|-------------------------|--|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD S. CHADWICK</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 31, 1981</b>           |   | 2b. HOUR<br>M                     |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 11 60</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>20</b>  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD  |                                   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> |                         |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12c. KIND OF BUSINESS OR INDUSTRY |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Spencer S.M. Chadwick</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elvina Stanley</b> |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)   |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Spencer Chadwick 5507 Lynview Ave.</b>   |                                   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR ARRHYTHMIA</b><br>4251<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE HYPERTROPHIC CARDIOMYOPATHY 22 YRS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 78</b> , to <b>Dec 80</b> , that (I) (we) last saw the deceased alive on <b>Dec 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>John T. Flaherty MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>4/1/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN T. FLAHERTY MD</b>   |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL BALT, MD 21205</b>                         |   |

|   |                            |   |   |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>4/6/81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>       |                            | 15a. DATE REC'D. BY REGISTRAR<br><b>APR 03 1981</b>         | 25. SIGNATURE<br><b>[Signature]</b>                               |

1968, 10 MONTH

1968, 10 MONTH

1968, 10 MONTH



1968, 10 MONTH

1968, 10 MONTH

1968, 10 MONTH



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  | REG. NO. 06831   |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Earl David (Chaney) Chainey</b>   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 6 19 81</b> |  | 2b. HOUR <b>M</b>   |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 30 36</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.                      |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 6 19 81</b>                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>                     |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY                             |  | 13c. CITY OR TOWN <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  | 13e. STREET ADDRESS <b>4306 Liberty Hgts Ave.</b>             |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Vernon W. Chaney</b>   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Esther C. Spicer</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>217-32-8552</b>  |  | 17. INFORMANT ADDRESS <b>Vernon Chainey 3919 Cedardale Rd.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt Injury to Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 2 28 19 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject fell</b>                              |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4306 Liberty Hgts. Ave., Baltimore City, Md.</b>                       |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |   |  |  |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER   |  | DATE SIGNED <b>3/7/81</b>                                     |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |   |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE <b>3/14/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Pk.</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>          |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                 |  |  |  |

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ID  
C

Handwritten signature

MAR 10 1941

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 3 2

|  |  |  |  |
|--|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLIFTON CHAMBERLAINE</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR 3 12 81   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>Black</b>   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 2 3 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSP.</b>  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>UNKNOWN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY <b>BALTO.</b>  |  |
| 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS <b>2024 PENROSE AVE.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Moses Chamberlaine</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HATTIE HOPKINS</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO <b>221-18-5084</b>   |  |
| 17. INFORMANT <b>MEDICAL RECORDS</b>   |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>C.O.P.D.</b>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-12</b> , 19 <b>81</b> , to <b>3-12</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3-12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |
| 22b. SIGNATURE <b>Oscar E. Ferdinandini M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED <b>3-12-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSCAR E. FERNANDINI M.D.</b>  |  | 22e. ADDRESS <b>BON SECOURS HOSP. BALTO. MD.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/16/81</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEM. PARK</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>WM.C. MARCH F/H INC. 1101 E. North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 13 1981</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   | REG. NO. 8 1 0 6 8 3 3   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Alexander Walker CHANDLEE</b><br><b>X ALEXANDER WALKER CHANDLEE</b>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>X 3 11 81</b>                             |  | 2b. HOUR<br><b>8:15A</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>X Dec. 23 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>X BALTO CITY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK HOME</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerical</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Office</b>                               |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>KES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>505 W. University Parkway</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George M. Chandlee</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Clara Rieman</b>                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  |   |   |   | 16b. SOCIAL SECURITY NO.<br><b>220-07-2301</b>                                   |  | 17. INFORMANT: Brother ADDRESS<br><b>Geo. M. Chandlee, Jr., Franklin, W. Va.</b> |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myotonic dystrophy</b><br><b>3592</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO OR AS A CONSEQUENCE OF<br>DUE TO OR AS A CONSEQUENCE OF |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>4/20/80</b> 19 to <b>3/11/81</b> 19, that (we) last saw the deceased alive on <b>3/11/81</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) DEGREE<br><b>W. B. Daniels, Jr. M.D.</b>                         |  | 22c. DATE SIGNED<br><b>3/11/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. B. Daniels, Jr.</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>Keswick 700 W. 40th St., Baltimore</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>March 3 1981</b>                                    |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sec. Proc.</b>                          |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto., Md.</b>       |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>STEWART &amp; MOWEN CO., 108 W. North Av., City 01</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McBrady</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |  |  | 8 1 0 6 8 3 4  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WON OK CHANG</b>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 81</b>   |  | 2b. HOUR<br><b>855A</b><br>M   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>ORIENTAL</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 27 81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b><br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KOREA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNK</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b><br>MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CCATS</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2339 E. FAYETTE</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CHA S. CHOI</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>217 88 3369</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>J1 SUCK CHANG ABOVE</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1550</b> IMMEDIATE CAUSE (a) <b>Hepatoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2/1 19 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/29 19 81</b> to <b>3/20 19 81</b> , that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. Levin</b>   |  |   |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/30/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Claudio Levin</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>Sinai Hospt</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>3/27/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>  |  |   |  |  |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 3 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Pietro McCready</b>   |  |

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Wm. H. C. ...

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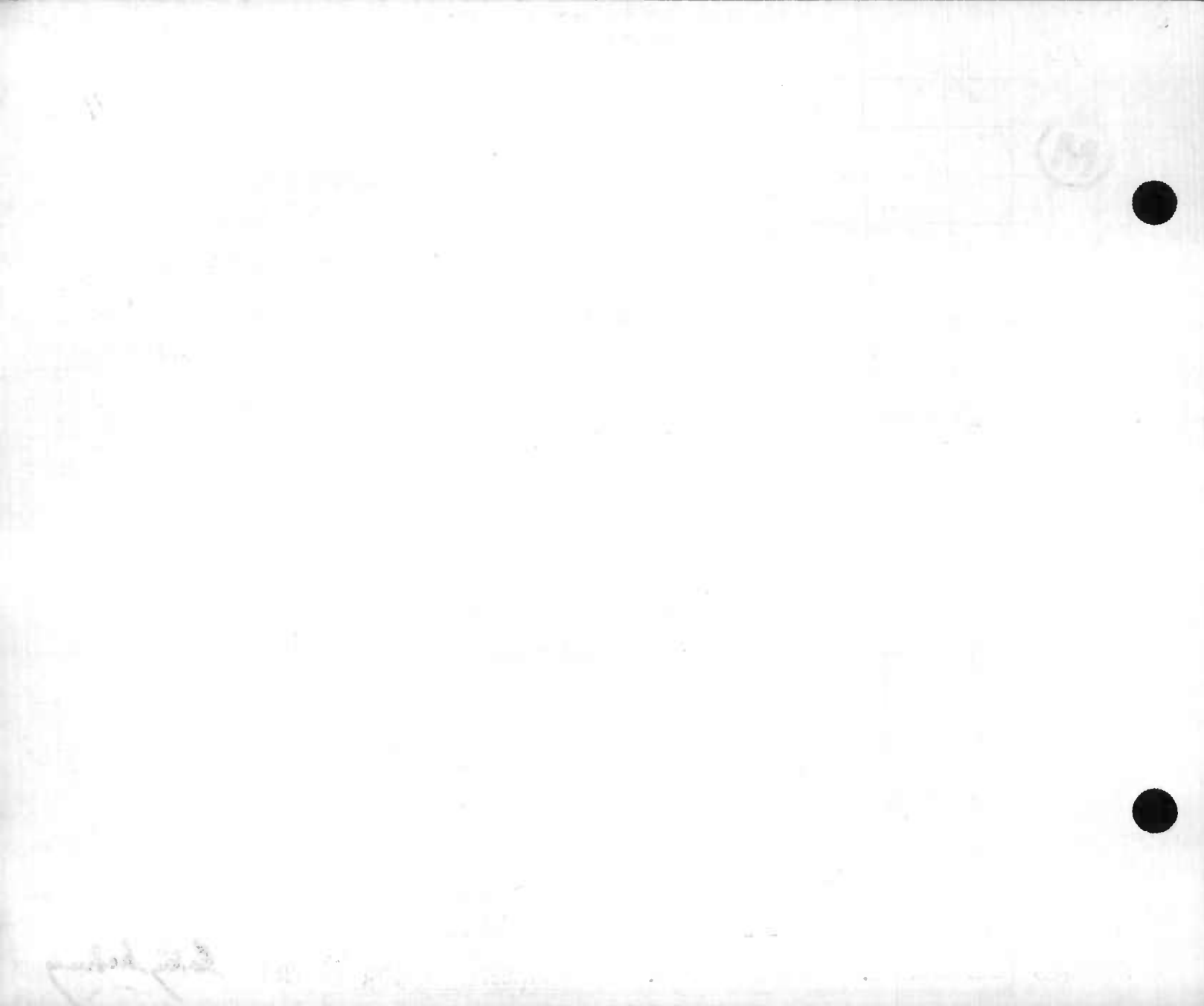


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 1 0 6 8 3 5   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>THOMAS CHAPMAN  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 29 81  |  | 2b. HOUR<br>10 04 PM   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 6 12  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE MD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTIMORE |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF EMPLOYED   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VAUDER CHAPMAN  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LORETTA VANDENBEGG  |  | 13e. STREET ADDRESS<br>415 FERNHILL AVE Z1Z15   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>217-03-8985  |  | 17. INFORMANT<br>FATIE CHAPMAN  |  | ADDRESS<br>SAME AS DECEASED  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1919<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Blasphemia Maligna grade 3-4</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>1 month</u> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>3/13/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Brain Tumor  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>81</u> to <u>3/29</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>TENENBAUM 9102 MD   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>3/29/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TENENBAUM  |  | 22e. ADDRESS<br>Sinai Hospital   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>4-3-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN CENTER   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ELIZABETH L. PHILLIPS 1721 N. MONROE STREET   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 06 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

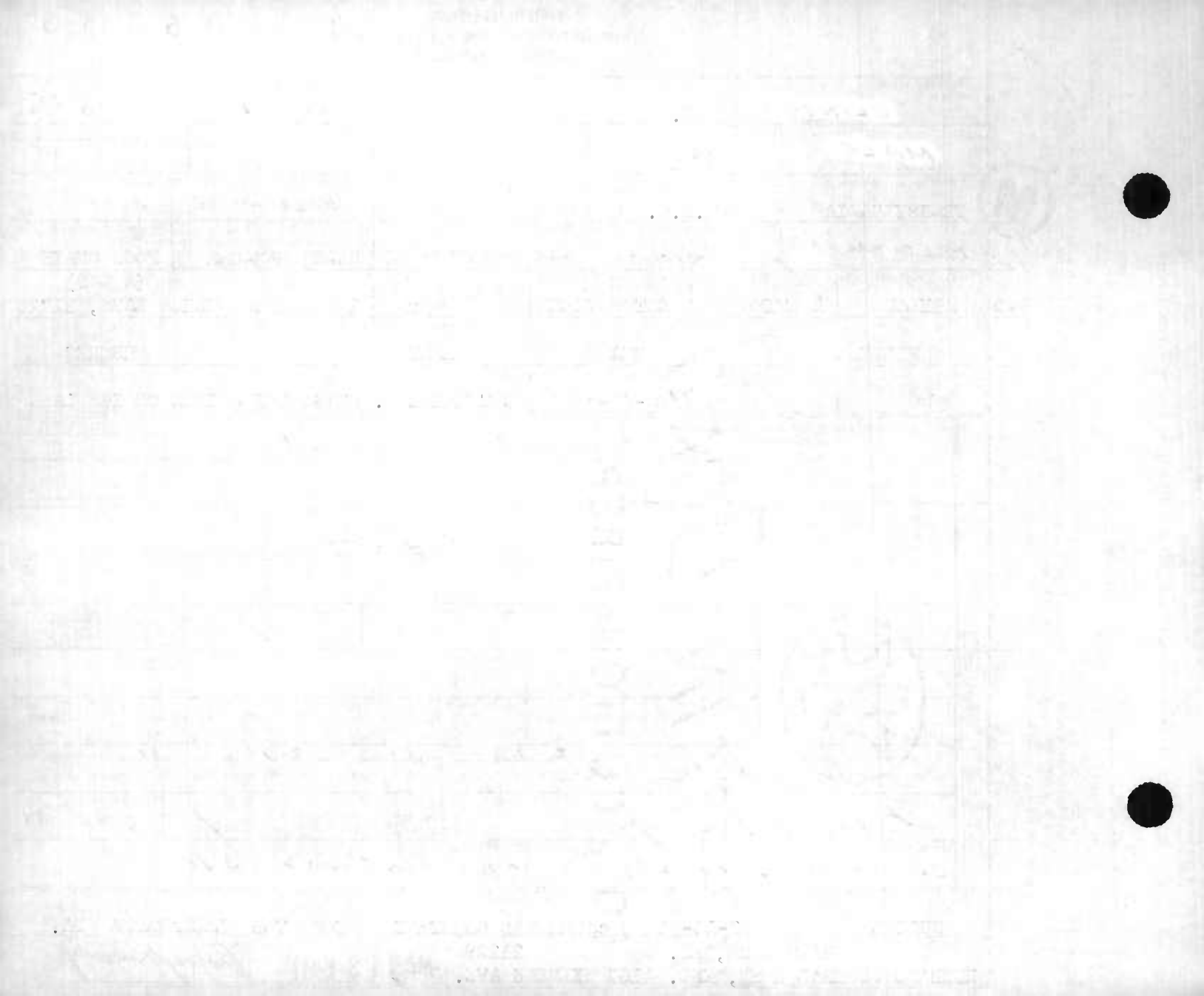
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLINTON H. CHASE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-10-81                         |   |  | 2b. HOUR<br>5:25 PM  |   |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 23 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES MANAGER    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD CHAIN  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |   |  |   | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>CATONSVILLE                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM CHASE  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY HUGHES   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>170-10-4856                                |   | 17. INFORMANT<br>ADDRESS<br>CATHERINE L. CHASE 205 MAIDEN CHOICE LANE  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac respiratory arrest.</i><br>5850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CHF</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>chronic renal failure.</i> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-12-1981</i> to <i>3-10-1981</i> , that (I) (we) last saw the deceased alive on <i>3-10-1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Cesar A. Vinuesa</i>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>3-10-81  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CESAR A. VINUEZA.   |  |   |  |   | 22e. ADDRESS<br>2300 PINEWOOD AVE.   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>03-14-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CATHEDRAL CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SCRANTON LACKAWANNA PA. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BALTIMORE, MD. ADDRESS<br>21229  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                      |  |   |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |   |  |   |  |  |   |  |   |  |

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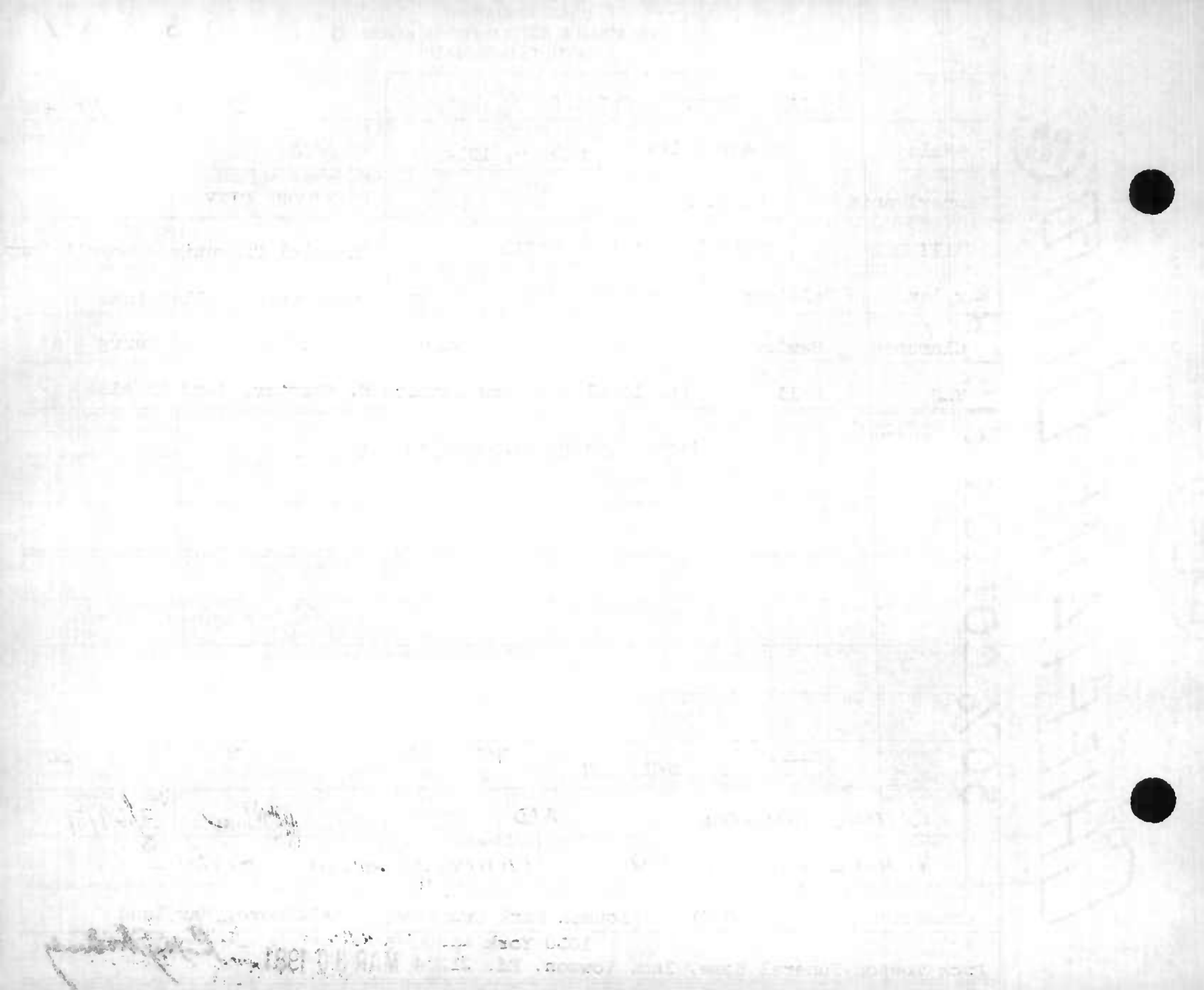


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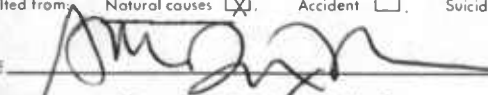

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM Curry CHESTER</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>29</b> YEAR <b>81</b>                                |  |   | 2b. HOUR<br><b>10<sup>00</sup> A.M.</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>9</b> YEAR <b>1914</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                              |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Financial Executive</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Noxell Corp.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Stevenson</b>  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Greenspring Valley Road</b>                         |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Clarence</b> MIDDLE <b>Hawley</b> LAST <b>Chester</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Athens</b> MIDDLE <b>E. M.</b> LAST <b>Curry</b>           |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW11</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs Patrice N. Chester, Same As #13e</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diffuse histiocytic lymphoma</b><br>2000<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> , 19 <b>81</b> , to <b>3/29</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Victoria Woolston</b>   |  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>3/29/81</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Victoria Woolston MD</b>   |  |   | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>  |  |   | 23b. DATE<br><b>3-30-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>                              |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> , COUNTY <b>Maryland</b> STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Ruck Towson Funeral Home, Inc.</b>   |  |   | ADDRESS <b>Towson, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>04 MAR 30 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                              |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |   |   |   |  |   |  |  | REG. NO. 06838  |  |
|--|--|----------------------|---|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES A. CHLAN</b>  |  |                      |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>21</b> YEAR <b>1981</b>                                   |   | 2b. HOUR <b>M</b>  |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b> |   | 5. DATE OF BIRTH<br>MONTH <b>08</b> DAY <b>02</b> YEAR <b>04</b>  |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>76</b> YRS.  |   | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>                                     |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>312 S. Lehigh St.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>IRONWORKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>REFINERY</b>              |   |  |
| 13a. COUNTY <b>MARYLAND</b>  |  |                      |   |   |   | 13b. CITY OR TOWN <b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS <b>312 S. LEHIGH ST.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b>CHLAN</b> LAST <b>FRANCES</b>  |  |                      |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JINDRA</b> MIDDLE <b>ST</b> LAST <b>JINDRA</b>  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                      | (IF YES, GIVE WAR OR DATES) <b>WW II</b>  |   |   | 16b. SOCIAL SECURITY NO. <b>218050729</b>  |   | 17. INFORMANT ADDRESS <b>ANNA J. LHOTSKY 2511 E. JEFFERSON ST</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |                      |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |   |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |  |   |  |  | 20. AUTOPSY?<br>HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |   |   |   |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br>  |  |                      |   | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER            |   |  |   | DATE SIGNED <b>3-23-81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |                      |   | ADDRESS <b>111 Penn St.</b>                                       |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      | 23b. DATE <b>4/4/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b> |  |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>MD.</b>                                   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John J. Wach</b> ADDRESS <b>2716 E. Monument St.</b>   |  |                      |   |   |   | 25a. DATE RECORDED BY REGISTRAR <b>APR 6 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |   |                                |  |   |
|--|---|---|---|---|---|--------------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH   |   |   | 2b. HOUR                       |  |   |
| FIRST MIDDLE LAST<br><b>ELMER L. CHRYSTAL Sr.</b>  |   |   | MONTH DAY YEAR<br><b>3/ 25/ 81</b>                                  |   |   | 11:45 PM                       |  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   |   | 7. IF UNDER 1 YEAR             |  |   |
| Male   | White   | MONTH DAY YEAR<br><b>Jan. 25 1914</b>   | 67 YRS.   |   |   | MONTHS DAYS HOURS MIN.         |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                                |  |   |
| Baltimore  | U.S.A.  |   |   | BALTIMORE CITY MD.  |   |                                |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |
| BALTIMORE  | ST. AGNES HOSPITAL  |   |   | Asst. Supervisor  |   |                                | Balto. Co.   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   |   |                                |  |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |                                |  |   |
| Md.  | Balto.  | Perry Hall  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 55 Chapeltowne Circle   |   |                                |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                       |   |   |                                |  |   |
| John S. Chrystal   |   |   | Viola Jeffery   |   |   |                                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)  |   |   | 16b. SOCIAL SECURITY NO.  |   |   | 17. INFORMANT ADDRESS          |  |   |
| No   |   |   | 212-01-4153   |   |   | Helen A. Chrystal same as 13   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:   |   |   |   |   |   |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Massive Pulmon. embolism</b>  |   |   |   |   |   |                                |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic infarcted vein thrombosis</b>  |   |   |   |   |   |                                |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent Pulmon. embolism</b>   |   |   |   |   |   |                                |  |   |
| DUE TO, OR AS A CONSEQUENCE OF <b>Congestive heart failure</b>   |   |   |   |   |   |                                |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |   |                                |  |   |
| <b>Infiltrate R lung</b>   |   |   |   |   |   |                                |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
| 3/25/81  |   | Recurrent Pulmon. embolism  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, ADVISE MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) |   |                                |  |   |
|  |   | P.M. 19   |   |   |   |                                |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |   |                                |  |   |
|  |   |   |   |   |   |                                |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> , 19 <b>81</b> , to <b>3/25</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/25</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |                                |  |   |
| 22b. SIGNATURE   |   |   | DEGREE  |   |   | 22c. DATE SIGNED               |  |   |
| <i>[Signature]</i>   |   |   |   |   |   | 3/25/81                        |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   | 22e. ADDRESS  |   |   |                                |  |   |
| DR. APOSTOLIDES  |   |   | 900 CATON AVENUE BALTIMORE MD 21229                                 |   |   |                                |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |   |
| Burial   |   | 3/30/81   |   | Lake View Mem. Park Balto.  |   |                                | Md.  |   |
| 24. FUNERAL DIRECTOR   |   |   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE     |  |   |
| Schimunek Funeral Home, Inc.   |   |   |   | 9705 Belair Rd. Balto. Md. 21236  |   | MAR 27 1981 <i>[Signature]</i> |  |   |

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

300 CATON AVENUE BALTIMORE MD 21229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 4 0

REG. NO.

|   |  |  |  |   |  |   |  |  |   |   |  |   |  |
|---|--|--|--|---|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vernon C. Chrystal Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>14</b> YEAR <b>81</b> |   |  | 2b. HOUR<br><b>6:40P.M.</b>   |  |  |   |   |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>05</b> DAY <b>07</b> YEAR <b>22</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                    |   | 8. IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ROOFER</b>               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ROOFING CO.</b> |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>801 WINTERS LANE, 21228</b>                                |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>S.</b> LAST <b>CHRYSTAL</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>VIOLA</b> MIDDLE <b></b> LAST <b>JEFFERY</b>   |  |   |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>VERNON C. CHRYSTAL, JR.</b>   |  | ADDRESS<br><b>3051 APT. E, ESSEX RD.</b>  |  | 21207  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>causes of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |   |  |   |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>congestive heart failure</b>   |  |  |  |   |  |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-27-</b> 19 <b>81</b> to <b>3-14</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-14</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Kareem Said</b>  |  |  |  |   |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3/15/81</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kareem Said</b>   |  |  |  |   |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>                       |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>03-18-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CROWNSVILLE VETERANS</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CROWNSVILLE A.A. MARYLAND</b>       |   |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |   |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-0600.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 4 1   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| REG. NO.   |  |   |  |   |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><i>Thomas F Clampet</i>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3/17/81</i>  |  |  |  |
| 3. SEX<br><i>M</i>   |  |   |  | 2b. HOUR<br><i>10<sup>30</sup></i> M  |  |  |  |
| 4. RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>02 02 00</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>P</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto Md</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ. Md. Hosp of Md</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>?</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <i>MD</i> 13c. COUNTY <i>CHARLES</i> 13d. CITY OR TOWN<br><i>Springfield Hosp</i> <i>Bytlesville</i>  |  |   |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13f. STREET ADDRESS  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>?</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>?</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220-54-6303</i>  |  | 17. INFORMANT ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia, bilateral</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>cancer of the larynx</i>   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>8 minutes</i><br><i>5 days</i><br><i>1 year</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Chronic lung disease, Right bundle branch block</i>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>none</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>none</i>   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/19</i> , 19 <i>81</i> , to <i>3/17</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>3/17</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Franklin M. Douglas MD</i>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br><i>3/17/81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Franklin M. Douglas MD</i>   |  |   |  | 22e. ADDRESS<br><i>Univ. Md. Hospital, Balt. Md</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>  |  | 23b. DATE<br><i>XXX 3-24-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Anatomy Board of Md.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 27 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert...</i>   |  |



Received

10-11-51

Secretary Board of M.

Board of M.

W.D. 10-11-51

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 6 8 4 2  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Clark, Roberta   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 27, 1981  |  |
| 3. SEX<br>Female   |  | 2b. HOUR<br>1:20 PM   |  |
| 4. RACE<br>Negro   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 1 1907  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital of Baltimore |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Retired   |  |
| 13b. COUNTY<br>Balto.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Teacher  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>David N. Wright   |  | 13c. STREET ADDRESS<br>2809 Mohawk Avenue   |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Gertrude Hooper  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |
| 16b. SOCIAL SECURITY NO.<br>217-22-9236  |  | 17. INFORMANT ADDRESS<br>Mr. David N. Wright 2827 Hillside Rd.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>4151<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) possible pulmonary embolus                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 mins<br>~30 mins   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>tachycardia x 11 years; RCV with Hemiparesis   |  |   |  |
| 19a. DATE OF OPERATION<br>March 9  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 9, 1981, to March 27, 1981, that (I) (we) last saw the deceased alive on March 27, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.A. KLEINERMAN, MD   |  | 22c. ADDRESS<br>Sinai Hospital of Baltimore<br>Belvedere @ Greenspring Balto, MD 21215  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>3-31-81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUS MENT PK  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ARBUS BALTO, CO MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>JOSEPH L. RUSS  |  | 25a. DATE REC'D BY REGISTRAR<br>APR 01 1981   |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  | 25c. REGISTRAR'S SIGNATURE<br>[Signature]   |  |



(M)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MELVIN J. CLAUSS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 13, 1981</b>                                |   |   | 2b. HOUR<br><b>7:35 AM</b>   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 27, 1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>73 4 1</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Band Leader</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. CITY OR TOWN<br><b>Balto.</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>6 Lake Forest Ct.</b>                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Clauss</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Simmel</b>                      |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-8300</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr. Michael Clauss Same</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Colonic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>(COLONIC CARCINOMA WITH METASTASIS)</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> , 19 <b>81</b> , to <b>3/13</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>W. Edwards</b>   |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/13/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. EDWARDS, M.D.</b>  |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD 21231</b> |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Mar. 16, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Essex Balto. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |

BP

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DET A. SAM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |   |  |   |                           | REG. NO. 06844   |  |
|--|--|----------------------|--|--|--|---|--|---|---------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT WILLIAM CLEMENTSON</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>2-7</b> |  | MONTH <b>2-7</b>  |                           | DAY <b>81</b>  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>14</b> YEAR <b>46</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>34</b> YRS.   |  | IF UNDER 1 YR. MONTHS _____ DAYS _____  |                           | IF UNDER 24 HRS. HOURS _____ MIN. _____  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b>                        |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>312 S. Fulton Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DRIVER</b>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY <b>COCA-COLA</b>                                       |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. COUNTY <b>---</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                           | 13e. STREET ADDRESS <b>312 S. FULTON AVENUE, 21223</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLARD</b> MIDDLE _____ LAST <b>CLEMENTSON</b>  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>EDNA</b> MIDDLE _____ LAST <b>HUNT</b>                               |  |   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>   |  |                      |  | (IF YES, GIVE WAR OR DATES) <b>VIETNAM</b>   |  | 16b. SOCIAL SECURITY NO. <b>517-52-3470</b>   |  | 17. INFORMANT <b>MARY LOUISE CLEMENTSON</b> ADDRESS <b>200 S. HARMISON ST</b>   |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4290</b> IMMEDIATE CAUSE (a) <b>Non-specific myocardial fibrosis, focal</b><br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                      |  |  |  |   |  |   |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |   |  |   |                           |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                           | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19 _____   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |  |   |                           |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____                                 |  |   |                           |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |   |                           |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |                      |  |  |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |   | DATE SIGNED <b>2-8-81</b> |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                      |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>02-11-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VA CEMETERY</b>   |  |   |                           | 23d. LOCATION<br>CITY OR TOWN <b>CROWNSVILLE A.A.</b> COUNTY _____ STATE <b>MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HUBBARD FUNERAL HOME, INC.</b> ADDRESS <b>4107 Wilkens Ave.</b>  |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>P. M. Kelly</b>   |                           |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

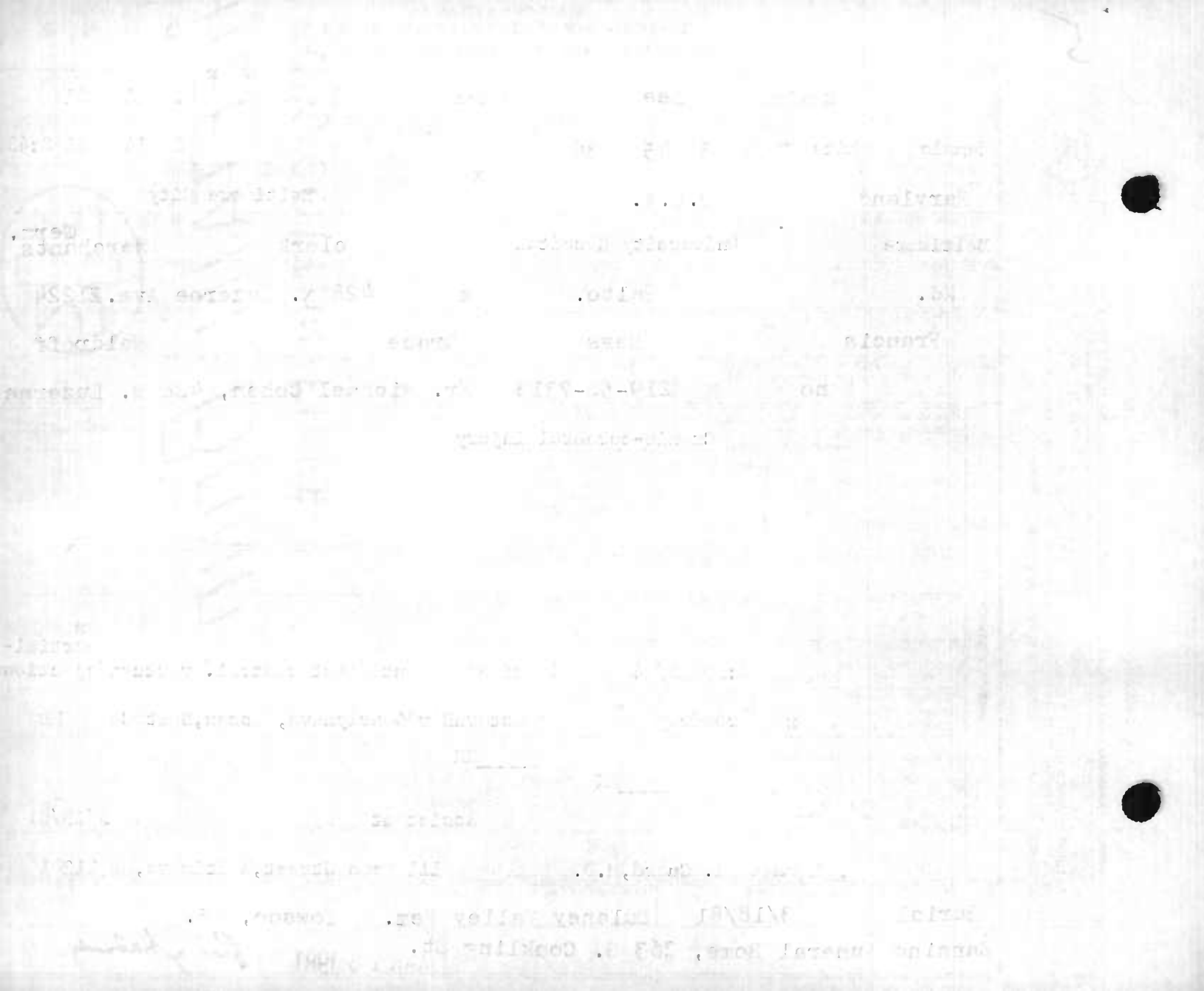
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06845

|  |   |   |  |   |                                      |   |  |
|--|---|---|--|---|--------------------------------------|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH                                     |  | MONTH DAY YEAR  |                                      | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | FIRST MIDDLE LAST   |  | 3 14 19 81  |                                      | M   |  |
| Sandra Lee Cohen   |   |   |  |   |                                      |   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.                     | 7c. DATE PRONOUNCED DEAD  | 7d. HOUR                                     |
| female   | white   | MONTH DAY YEAR  | LAST BIRTHDAY YRS.   | MONTHS DAYS   | HOURS MIN.                           | 3 14 19 81  | 8:43A  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Maryland   | U.S.A.  |   |  |   | Baltimore City                       |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  | University Hospital   |   |  | clerk   |                                      | Merm.   |  |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |   |  |
| Md.  |   |   | Balto.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 428 N. Luzerne Ave. 21224            |   |  |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME   |   |                                      |   |  |
| FIRST MIDDLE LAST  |   |   | FIRST MIDDLE LAST  |   |                                      |   |  |
| Francis Hess   |   |   | Grace Waldroff   |   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT ADDRESS   |                                      |   |  |
| no   |   | 219-58-7313   |  | Mr. Michael Cohen, 428 N. Luzerne   |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |  |   |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |   |   |  |   |                                      |   |  |
| IMMEDIATE CAUSE (a) <u>Cranio-cerebral injury</u>  |   |   |  |   |                                      |   |  |
| 8160   |   |   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |   |                                      |   |  |
| (b) _____  |   |   |  |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |   |                                      |   |  |
| (c) _____  |   |   |  |   |                                      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |   |   |  |   |                                      |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |                                      | 20. AUTOPSY?  |  |
|  |   |   |  |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |   |  |
|  |   | HOUR A.M. MONTH DAY YEAR                                    |  | partial-  |                                      |   |  |
|  |   | 6:50A 3/14 19 81  |  | driver of auto/lost control/overtake/ejection                                 |                                      |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |                                      |   |  |
|  |   | roadway   |  | Eastern Blvd & Marlyn Ave, Essex, Balto Co MD                                 |                                      |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Accidental causes</u> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |  |   |                                      |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)   |  | DATE SIGNED   |                                      |   |  |
| <i>Hormez R. Guard</i>   |   | M.D. Assistant  |  | 3/15/81   |                                      |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS   |  |   |                                      |   |  |
| Hormez R. Guard, M.D.  |   | 111 Penn Street, Baltimore, MD 21201                        |  |   |                                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                          |  | 23d. LOCATION   |                                      |   |  |
| Burial   | 3/18/81   | Dulaney Valley Mem.   |  | Towson, Md.   |                                      |   |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |                                      |   |  |
| Zammino Funeral Home, 263 S. Conkling St.  |   | MAR 18 1981   |  | <i>Jeffrey H. Hardy</i>   |                                      |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

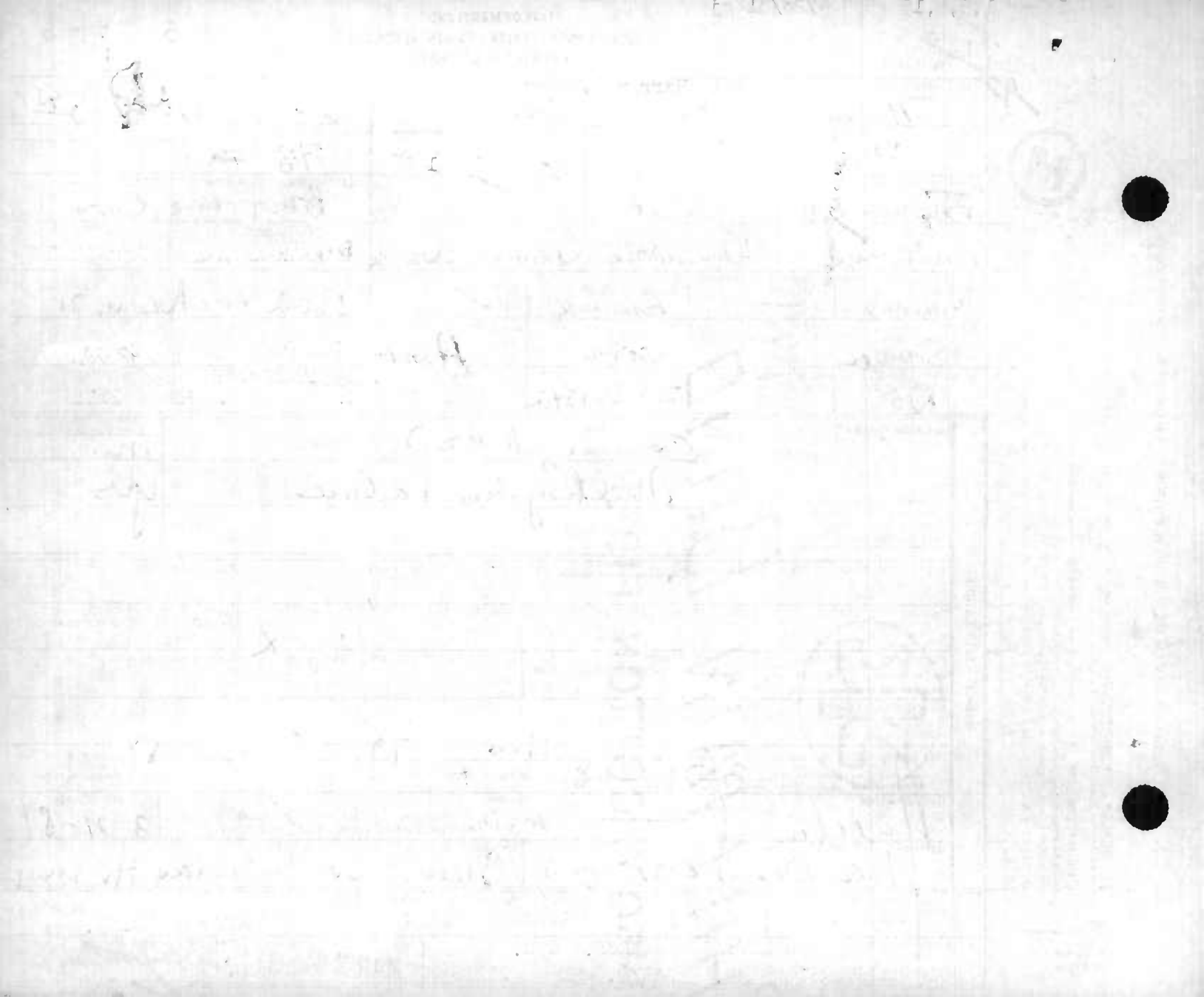
|  |  |  |   |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>HARRY S. COHN</b>  |  |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>21</b> YEAR <b>81</b>   |  |  | 2b. HOUR <b>8:45 P.M.</b>  |  |   |  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>9</b> YEAR <b>1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> <b>77</b> YRS. MONTHS <b>7</b> DAYS <b>7</b> |  | IF UNDER 1 YEAR IF UNDER 24 HRS   |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY MD</b>                         |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LOWENDALE GERIATRIC HOSPITAL</b> |   |  |  | 12a. USUAL RESIDENCE (TYPE WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>APPLIANCES</b>   |  |  |
| 13a. STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>—</b>  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>5602 KEY AVENUE, 21</b> |  |
| 14. FATHER'S NAME FIRST <b>SAMUEL</b> MIDDLE <b>—</b> LAST <b>COHEN</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>JENNIE</b> MIDDLE <b>—</b> LAST <b>COHEN</b>  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>213-044542</b>   |   | 17. INFORMANT <b>MRS. MARGARET COHN</b>  |  | <b>5602 KEY AVE. BALTO., MD</b>  |  | <b>21215</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Generalized ASD</b> (b) <b>Multi-system Failure</b> (c) <b>—</b>  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>yes</b> <b>yes</b>  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>—</b>  |  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/21/81</b> to <b>3-21-81</b> , that (I) (we) lost the deceased alive on <b>3/21</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE <b>Noel David List M.D.</b>   |  |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <b>3-21-81</b>  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NOEL DAVID LIST M.D.</b>  |  |  | 22e. ADDRESS <b>Greenway Belvedere Apts</b>   |  |  |  |  |   |  |  |
| 23a. BURIAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>3/24/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN BALTO. MD</b>                        |   |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>                                      |  |   |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |   |  |  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified to the State Dept. of Health and Mental Hygiene.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |   |   | REG. NO.  |  |
|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CAMILLO V COLAJEZZI</b>  |   |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>27</b> YEAR <b>81</b>                                |   | 2b. HOUR<br><b>2:04 P.M.</b>  |  |
| 3 SEX<br><b>Male</b>  | 4 RACE<br><b>White</b>  | 5 DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>15</b> YEAR <b>17</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GENERAL HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Capt. - Seaman</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>4614 Parkside Dr. 21206</b>   |   |  |
| 14 FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Colajezzi</b> LAST <b>Colajezzi</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sadie</b> MIDDLE <b></b> LAST <b>Unknown</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO<br><b>164-14-2811</b>  |   | 17 INFORMANT ADDRESS<br><b>Thelma Colajezzi 4614 Parkside Dr.</b>   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b>  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>POSSIBLE ACUTE MYOCARDIAL INFARCT</b><br>(c) <b>CEREBRAL THROMBOSIS &amp; HEMIPARESIS.</b>  |   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3/3</b> 19 <b>81</b> , to <b>3/27</b> 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>3/27</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death. |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>C. Chouvalit Apibunyopas, M.D.</b>   |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/27/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. CHOUVALIT APIBUNYOPAS</b>  |   |  |   | 22e. ADDRESS<br><b>NORTH CHARLES GENERAL HOSP.</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>30 Mar. 81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cremat.</b>                                 |   | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Baltimore, Md.</b>                |  |
| 24 FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |   | ADDRESS<br><b>3311 Brehms Lane - Balto.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |



1981 MAR 31 18 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 4 8   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| TODD RUSSELL COLDREN<br>BABY BOY COLDREN   |  |   |  | 3 9 81 97 A M   |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>March 3, 1981   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>3 YRS. 9 MONTHS 6 DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>21204  |  |
| 14. FATHER'S NAME<br>K. Russell Coldren  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Susan R. Marquette  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>-----   |  | 17. INFORMANT ADDRESS<br>K. Russell Coldren Balto. Co., Md. 21204   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>7708<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immaturity</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9 19 81, to 3/9 19 81, that (I) (we) lost saw the deceased alive on 3/9 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Michael A. Simmons, MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/9/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael A. Simmons  |  |   |  | 22e. ADDRESS<br>601 North Broadway Baltimore Md. 21205  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 11, '81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem. Gar. Balto. Co., Md.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson 8521 Loch Raven Blvd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |                                    |  |  |  |         |                 |
|---|--|---|--|---|------------------------------------|--|--|--|---------|-----------------|
| 1. FOR STATE REGISTRAR  |  |   |  |   |                                    |  |  |  |         |                 |
| CERTIFICATE OF DEATH  |  |   |  |   |                                    |  |  |  |         |                 |
| REG. NO.  |  |   |  |   |                                    |  |  |  |         |                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH                  |  | MONTH                                      |  | DAY     | YEAR            |
| Jane R. Cole  |  |   |  |   | March 2, 1981                      |  |  |  | 6:00P M |                 |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |         | IF UNDER 24 HRS |
| Female  |  | White   |  | March 6, 1924   |                                    | 56 YRS.  |  | MONTHS   |         | DAYS            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |         |                 |
| Pennsylvania  |  | U.S.A.  |  |   |                                    | Baltimore City, MD.  |  |  |         |                 |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |         |                 |
| Baltimore   |  | Maryland General Hospital   |  |   |                                    | Home Maker   |  | Own Home   |         |                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |                                    |  |  |  |         |                 |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |         |                 |
| Maryland  |  | Baltimore   |  | Perry Hall  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 3737 E. Joppa Road   |         |                 |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME           |  |  |  |         |                 |
| FIRST MIDDLE LAST   |  |   |  |   | FIRST MIDDLE LAST                  |  |  |  |         |                 |
| Nolan V. Rosier   |  |   |  |   | Katherine E. Berthold              |  |  |  |         |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS                      |  |         |                 |
| No  |  |   |  |   | 178-16-2579                        |  | Lawrence V. Cole Same as #13.              |  |         |                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |                                    |  |  |  |         |                 |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |                                    |  |  |  |         |                 |
| IMMEDIATE CAUSE (a) Pneumonia   |  |   |  |   |                                    |  |  |  |         |                 |
| DUE TO, OR AS A CONSEQUENCE OF (b) Meningioma   |  |   |  |   |                                    |  |  |  |         |                 |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |                                    |  |  |  |         |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                                    |  |  |  |         |                 |
| MEDICAL CERTIFICATION   |  |   |  |   |                                    |  |  |  |         |                 |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |                 |
| 1/29/81   |  |   | Meningioma   |   |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |         |                 |
|   |  |   | P.M. 19  |   |                                    |  |  |  |         |                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |         |                 |
|   |  |   |  |   |                                    |  |  |  |         |                 |
| 22a. I certify that (X) (this hospital) attended the deceased from January 27, 19 81, to March 2, 19 81, that X (we) lost saw the deceased alive on March 2, 19 81, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (and not) view the body after death. |  |   |  |   |                                    |  |  |  |         |                 |
| 22b. SIGNATURE<br>Michael S. Stephens M.D.  |  |   |  |   |                                    | DEGREE   |  | 22c. DATE SIGNED   |         |                 |
|   |  |   |  |   |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 2/2/1981   |         |                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |                                    | 22e. ADDRESS   |  |  |         |                 |
| Michael S. Stephens   |  |   |  |   |                                    | c/o Maryland General Hospital  |  |  |         |                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |         |                 |
| Burial  |  |   | Mar. 6, 1981   |   | Dulaney Valley Cem.                |  | Cockeysville Balto., Md.                   |  |         |                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |   |                                    | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |         |                 |
| Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204   |  |   |  |   |                                    | MAR 4 1981   |  |  |         |                 |

BP 4



**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR   |  |
| Josephine   |  | Cole   |  | 3/9/81   |  |   |  | 12 30 <sup>A</sup>   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7a. UNDER 1 YEAR   |  |
| F   |  | B  |  | MONTH DAY YEAR   |  | 95 YRS.   |  | MONTHS DAYS HOURS MIN  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7c. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Maryland  |  | USA  |  |  |  | Baltimore City  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Lutheran Hospital  |  |  |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1106 Druid Hill N/H  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| FIRST MIDDLE LAST Joseph Cole   |  |  |  | FIRST MIDDLE LAST Martha E. Brown  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  | Apt. 110   |  |
| No  |  | 212-22-6308  |  | Lillian Yates  |  | 1701 Eutaw Place  |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 4280  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic organic brain syndrome</u>  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>03/04</u> 19 <u>81</u> , to <u>03/09</u> 19 <u>81</u> , that (I) (we) lost <u>3/9</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| <u>[Signature]</u>  |  |  |  |  |  |   |  | <u>3/9/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS  |  |  |  |
| <u>MOSES GERREMANIAN</u>  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY STATE   |  |
| Burial  |  | 3/16/81  |  | Mount Auburn Cem.  |  | Anne Arundel Co.,   |  | MD.  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| WM.C.MARCH F/H INC. 1101 E. North Ave.  |  |  |  |  |  | MAR 11 1981   |  | <u>[Signature]</u>   |  |



*[Handwritten signature]*

1801 / 1 MAR

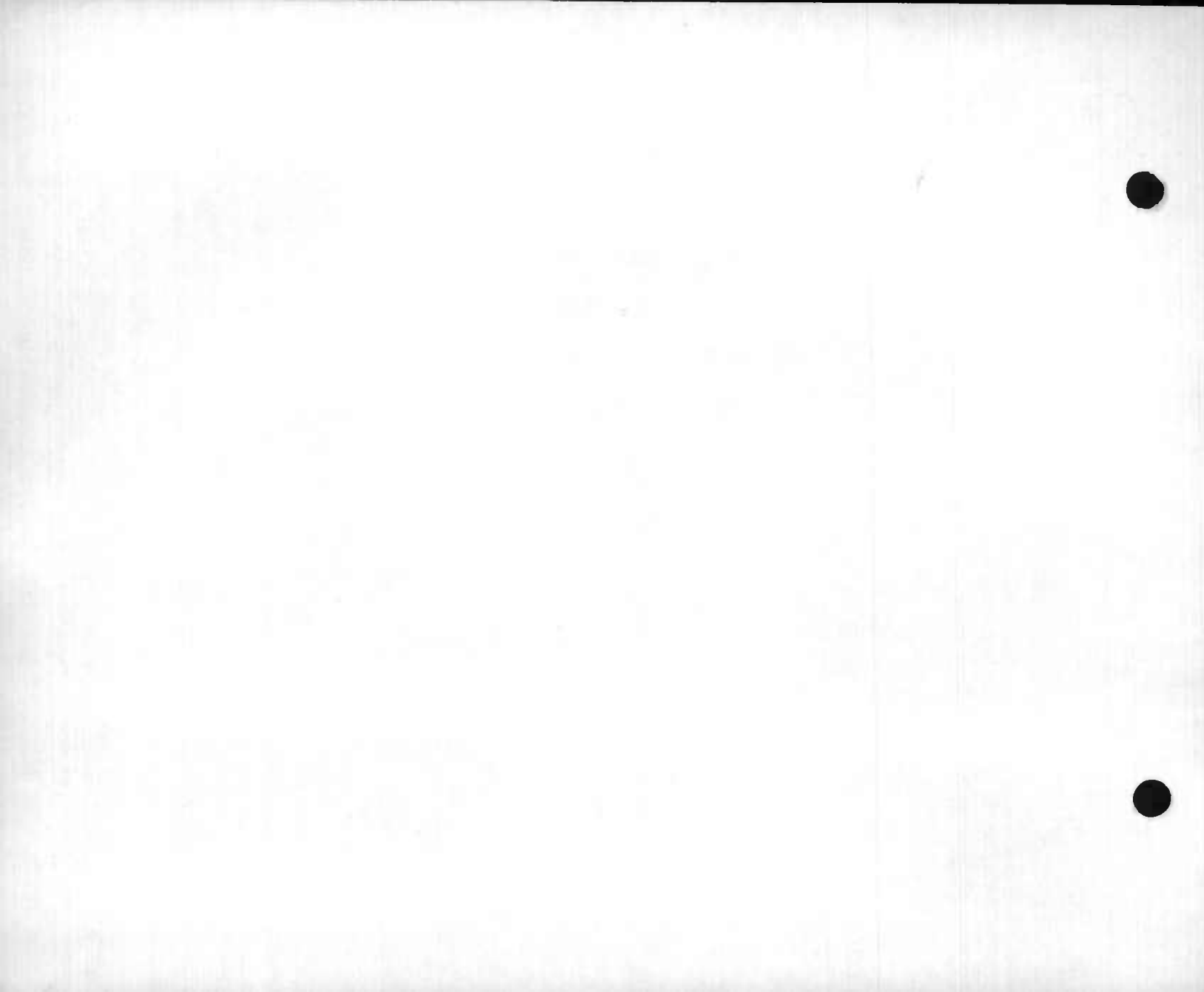


VOIDED DEATH CERTIFICATE NUMBER

81-06851

DUPLICATE ON BABY GIRL COLEMAN

DIED: 3/13/81 - CITY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 8 5 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| Corman baby girl  |  |  |  | 3 13 81   |  |  |  |
| 3 SEX F   |  | 4 RACE B   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
|   |  |  |  | 3 13 81   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MD  |  | USA  |  |   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Mercy Hospital   |  |   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Md.   |  |  |  |   |  | Baltimore  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| Kevin Burden  |  |  |  | Cynthia Coleman   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |
| No  |  | None   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>7651 IMMEDIATE CAUSE (a) Immaturity<br>DUE TO, OR AS A CONSEQUENCE OF (b) wt weight 12 3/4 oz<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  |  |  |
| Moushira Elshafi  |  |  |  | 22e. ADDRESS  |  |  |  |
| Mercy Hospital  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |
| REMOVAL   |  | 3-19-81  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25. DATE RECEIVED BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| ATTORNEY BOARD OF MD. BART. MD  |  |  |  | MAR 23 1981   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE FILES OF THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

|   |  |   |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
|---|--|---|--|--|--|--|--|-------------------------|--|------------------|--|--------------------------|--|-------|--|----------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                       |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN OF DEATH |  | MONTH            |  | DAY                      |  | YEAR  |  | 2b. HOUR |  |      |  |          |  |
| GEORGE Lawrence   |  | COLEMAN   |  | Sr.  |  |  |  | 3-1-81                  |  | 19               |  |                          |  |       |  |          |  |      |  |          |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  | IF UNDER 1 YR.          |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY      |  | YEAR |  | 2d. HOUR |  |
| male  |  | white   |  | Dec. 26, 1924  |  | 56 YRS.  |  |                         |  |                  |  | 3-1-81                   |  | 19    |  |          |  |      |  | 12:34    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| Maryland  |  | U.S.A.  |  |  |  | Baltimore City   |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| Baltimore   |  | S.T.U. University Hospital  |  | Vice Pres.   |  | Banking  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS     |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| Maryland  |  |   |  | Baltimore  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 6138 Marlora Road       |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| George E. Coleman   |  | Mary C. Stumpf  |  |  |  |  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)        |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| Yes   |  | W.W. 11   |  | Mrs. Rose Marie Coleman  |  | same.  |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | PART I DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a) Multiple injuries  |  | DUE TO, OR AS A CONSEQUENCE OF                           |  |                         |  |                  |  |                          |  |       |  |          |  |      |  |          |  |
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Memorandum

TO : Mr. Tolson

FROM : Mr. Clegg

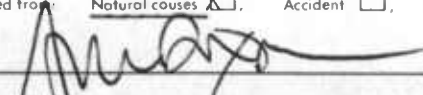
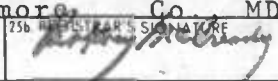
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RE: [Illegible]

DATE: [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |   |  |  |   |  | REG. NO. 06854 |  |
|--|-------------------------|---|---|---|---|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MATILDA COLEMAN</b>   |                         |   |   |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 3 1 19 81 |  | 2b. HOUR <b>7:44</b>  |  |                |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>negro</b> | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>15</b> YEAR <b>1965</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>65</b> YRS. | 7. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7c. DATE PRONOUNCED DEAD <b>3 1 19 81</b>  |  | 7d. HOUR <b>7:44</b>  |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Johns Hopkins Hospital (DOA)</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |   |   |   |  |  |   |  |                |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 13e. STREET ADDRESS<br><b>802 McDonogh Street</b>                                   |  |                |  |
| 14. FATHER'S NAME<br><b>William</b>  |                         |   |   | MIDDLE <b>Scott</b>   |   | 15. MOTHER'S MAIDEN NAME<br><b>Matilda</b>   |  | MIDDLE <b>Sheppard</b>  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>217-05-9219</b>  |   | 17. INFORMANT<br><b>Bishop W. Coleman</b> ADDRESS <b>802 McDonogh St.</b>   |   |  |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                         |   |   |   |   |  |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |                         |   |   |   |   |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |  |  |   |  |                |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   |   |   |  |  | DATE SIGNED <b>3-2-81</b>   |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS <b>111 Penn St.</b>   |   |   |   |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         | 23b. DATE<br><b>3/5/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD.</b>                    |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WM.C. MARCH F/H INC.</b> ADDRESS <b>1101 E. North Ave.</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br>   |   |  |  |   |  |                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |   |   |  |   |  |
|---|--|--|---|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |   | REG. NO.   |   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Elijah Colter</i>   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3 11 81</i>   |   |   |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>8 10 23</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>57</i> YRS.                           |   | 7b. HOUR<br><i>2 10 PM</i>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>South Carolina</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Duke Land Nursing Home</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>N/A</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><i>Maryland</i>   |  |  |   |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Clifton Colter</i>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Hester Hook</i>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  |  |   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><i>Frenchseal Colter 510 N. Schroeder St</i> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4100</i> IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION - MYOCARDIAL FAILURE</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-12</i> , 19 <i>79</i> , to <i>3-11</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3-11</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                   |  |  |   |   |  |   |   |  |   |  |
| 22b. SIGNATURE DEGREE<br><i>Thomas W. Harris M.D.</i>   |  |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><i>3-11-81</i>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>THOMAS W. HARRIS, M.D.</i>  |  |  |   |   | 22e. ADDRESS<br><i>4200 EDMONDSON AVE BALTIMORE, MD</i>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>3/16/81</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Memorial Pk. Baltimore Co.</i>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>MD.</i>                 |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>WM.C.MARCH F/H INC.</i>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 12 1981</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Bandy</i>                  |  |   |  |

1913



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 5 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                             |   |  |
|---|--|--|---|---|-----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID E. CONE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 28 81</b> |   | 2b. HOUR<br><b>1:00P.M.</b> |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 31 13</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   |                             | 13c. STREET ADDRESS<br><b>1217 Calvert St.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin F. Cone</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gwendolgra Rees</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                             |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>057-10-7172</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Northgate Apt. One<br/>Mile Rd., N.J.</b>   |   |   |                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF SCALP AND PALE</b><br>1734<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |                             |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                             |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                             |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/31/81</b> to <b>3/28/81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/28/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                             |   |  |
| 22b. SIGNATURE<br><b>Nelson Benders</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                             | 22c. DATE SIGNED<br><b>3/28/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NELSON BENTERS</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>  |   |   |                             |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/30/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>   |                             | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

509A

1944

3200 D 02AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must not be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                                       |   |  |  |  |   |                     | 8 1 0 6 8 5 7  |  |
|--|--|---|---------------------------------------|---|--|--|--|---|---------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.                              |   |  |  |  |   |                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST<br>WALTER W. CONROY |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 10, 1981  |  |   | 2b. HOUR<br>4 P. M. |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 24, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                 |                     | 7. IF UNDER 24 HRS<br>HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3113 GREENMOUNT AVE. |                                       |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ROOFER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ROOFING      |                     |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |                                       |   |  |  |  |   |                     |  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY   |                                       | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>3113 GREENMOUNT AVE. 21218 |                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN CONROY  |  |   |                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA B. COCHRAN  |  |  |  |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-07-3169A   |                                       | 17. INFORMANT<br>ADDRESS<br>EVELYN J. CONROY 3113 GREENMOUNT AVE 21218  |  |  |  |   |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>4039<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Nephrosclerosis</u><br>(c) <u>Generalized Arteriosclerosis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Diabetes Mellitus, Arteriosclerotic Cardiovascular Dis., Urinary Tract Infection</u> |  |   |                                       |   |  |  |  |   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 days |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 2</u> , 19 <u>75</u> , to <u>Mar 10</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>MAR 9</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                                       |   |  |  |  |   |                     |  |  |
| 22b. SIGNATURE<br><u>Edward F. Cotter</u>  |  |   |                                       | DEGREE  |  |  |  | 22c. DATE SIGNED<br><u>Mar 11, 1981</u>           |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD F. COTTER M.D.   |  |   |                                       | 22e. ADDRESS<br>1900 E. NORTHERN PKWY. BALTO. MD.   |  |  |  |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAR. 13, 1981  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY MEM. GONS.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COCKEYSVILLE BALTO. MD.  |  |   |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME  |  |   |                                       | ADDRESS<br>6500 YORK RD. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981      |                     | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 5 8   |  |   |  |
|--|--|---|--|---|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| Gordon F. Centee   |  |   |  | 3-28-81   |  |   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 2b. HOUR  |  |
| Male   |  | Cau.  |  | 8 31 01   |  | 9:40 AM   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maine  |  | USA   |  |   |  | Balto. City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |
| Balto.   |  | Long Green Nursing Home   |  | Entertainment   |  | Entertainment   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md   |  |   |  | Balto   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 13e. STREET ADDRESS   |  |   |  |
| Richard Centee   |  | Mabel Gordon  |  | 3209 N. Charles St.   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |
| No   |  | 577-03700   |  | Mrs. G. Centee  |  | Balto. Md. 21218<br>3209 N. Charles St.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (a) Cardio Respiratory failure   |  |   |  |   |  |   |  |
| 4960 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |
| (b) Pneumonia, Aspiration  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |  |
| (c) Chronic obstructive lung disease   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| Esophageal stricture & spasms  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|  |  | P.M. 19   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/24/81 to 3/28/81, that (I) (we) lost<br>saw the deceased alive on 3/24/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>    |  | 22d. DATE SIGNED  |  |
| Norman R. Freeman  |  | MD  |  |   |  | 3/31/81   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22f. ADDRESS  |  |   |  |   |  |
| NORMAN R. FREEMAN R  |  | 11 W. 29th St, Baltimore, Md  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Removal  |  | 3/28/81   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| Anatomy Board  |  | APR 10 1981   |  | History/Anatomy   |  |   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

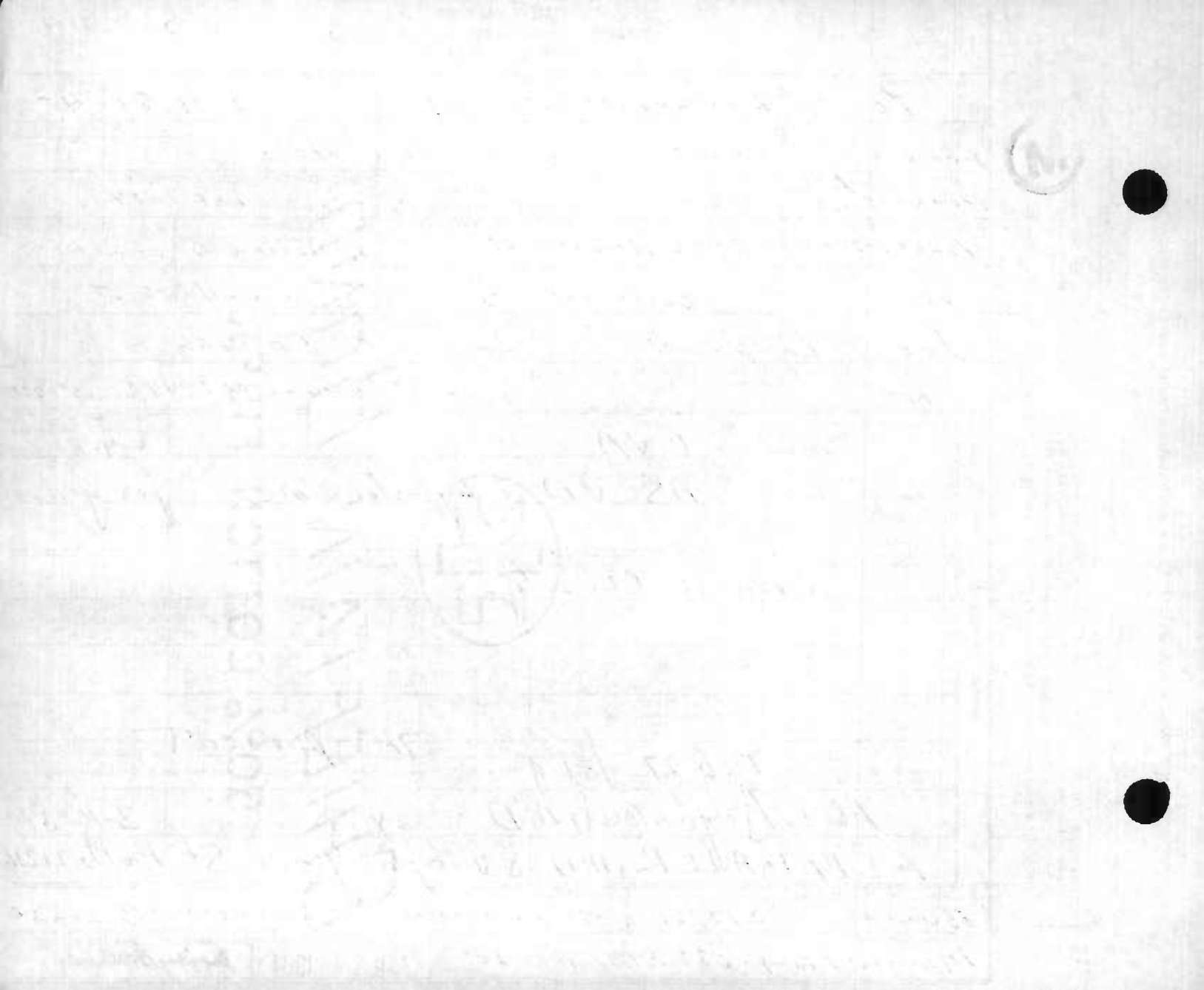
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |   |   |   |   |   |
|---|--|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IDA McLAUGHLIN CONWAY</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 4 81</b> |   |   | 2b. HOUR<br><b>4 A</b>  |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 4 41</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HAUNNETT CO.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2572 HOLLINS ST</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOE McLAUGHLIN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOUISE McDOUGAL</b>   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br><b>JOYCE McLAUGHLIN 3944 BELVIEW</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD - hypertension</b> for years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Extreme Obesity.</b>  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3-4-81</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Extreme Obesity.</b>   |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>76</b> , to <b>present</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 27</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>A. I. Baykaler, M.D.</b>   |  |   |   | 22c. DATE SIGNED<br><b>3-10-81</b>  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. I. BAYKALER, M.D.</b>                            |   |
| 22e. ADDRESS<br><b>831 Poplar Grove St. Balt. 21216</b>   |  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/17/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD 21230</b>                        |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Markus P. Nims</b>   |  |   |   | 24b. ADDRESS<br><b>638 29th Ave NW</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>   |   |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. K...</b>   |   |   |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 6 0

FOR  
STATE  
REGISTRAR

REG. NO.

|  |                         |  |  |   |  |  |
|--|-------------------------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mammie Cook Cook</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 6 81</b> |   | 2b. HOUR<br><b>2:00 PM</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUN. 6 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. CITY OR TOWN OF DEATH<br><b>Balt. MD</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT JOYNER</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ANDERSON</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>?</b>   |                         | 17. INFORMANT<br>ADDRESS<br><b>REV. HENRY COOK 5503 FERNPARK AVENUE 21207</b>  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIABETIC KETOACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4 DAYS</b>  |                         |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>45 MINUTES</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> , 19 <b>81</b> , to <b>2-6</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-6</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |                         |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Carlton C. Greene MD</b>  |                         | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2-6-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLTON C. GREENE</b>  |                         | 22e. ADDRESS<br><b>1501 PENTRIDGE ROAD</b>   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>2/12/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NAT. MEM. PK.</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL (PRINCE GEORGE) MD.</b>  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>  |                         | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.



2014-10

2014-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>WILLIAM A. COOK</u>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>March 1, 1981</u> |  | 2b. HOUR<br><u>8:20 P.M.</u>   |   |  |  |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>B</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>04 02 36</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>54</u> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>WASH. D.C.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIVERSITY OF MD. HOSP.</u> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Accountant</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Brokerage</u>            |  |
| 13a. STATE<br><u>md.</u>  |  |   |  |  |  | 13b. COUNTY<br><u>Pr. George</u>  |  | 13c. CITY OR TOWN<br><u>Capitol, Hts</u>                         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Frank R. Cook, Sr.</u>   |  |   |  |  |  | 15. MOTHER'S MIDDLE NAME<br>FIRST MIDDLE LAST<br><u>ELIZABETH Kinney</u>              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>YES</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>291-22-5784</u>  |  | 17. INFORMANT<br><u>Frank R. Cook, Jr.</u>   |  | ADDRESS<br><u>5136 S. Dak. Ave. Wash., D. C.</u>                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>dehydration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>esophageal carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>acute renal failure, radiation hepatitis, cholestatic jaundice 20% metastasis</u>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><u>January 26, 1981</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Esophageal obstruction</u>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>February 16, 1981</u> to <u>March 1, 1981</u> , that (1) (we) lost saw the deceased alive on <u>March 1</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                 |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>BR Houston</u>   |  |   |  | DEGREE<br><u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>March 1, 1981</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>BR Houston, M.D.</u>  |  |   |  | 22e. ADDRESS<br><u>U. of Md. Hosp. Greene St., Baltimore, Md 21212</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>3/6/81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lincoln Memorial Cem.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Suitland, Maryland</u>               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>McGuire Funeral Ser.</u> ADDRESS <u>7400 Ga. Ave. N.W.</u>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 10 1981</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                      |  |  |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |  |   |   |   |   |  | REG. NO. 06862  |  |
|--|-------------------------|---|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOE THOMAS CORNISH</b>  |                         |   |  |  |   |   |   |   |  | 2a. DATE OF DEATH<br>KNOWN ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/><br>MONTH DAY YEAR<br><b>3-18 81</b> |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 14 1965</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>15 YRS.</b>                | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3-18 81</b>                                    |   | 7b. HOUR<br><b>10:05 a M</b>                    |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>           |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital S.T.U.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY               |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |  |   |   |   |   |  |   |  |
| 13a. STATE<br><b>Md</b>  |                         | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>                                |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1518 Brady Avenue</b> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Solomon</b>   |                         |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Geraldine Cornish</b>   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                         |   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>Joe Solomon 1300 Angleia Street</b>                                 |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>Blunt force injury to the head</b><br>IMMEDIATE CAUSE (a) <b>9C82</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |   |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |                         |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOURS MONTH DAY YEAR<br><b>5:20 PM 2-24- 81</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject struck in head</b>  |   |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b> |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>1518 Brady Avenue Baltimore, Maryland</b>  |   |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                         |   |  |  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korek</b><br>EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korek, M.D.</b>  |                         |   |  |  | TITLE (SPECIFY)<br><b>Assistant</b><br>MEDICAL EXAMINER   |   |   |   |  | DATE SIGNED<br><b>3-19-81</b>   |  |
| ADDRESS<br><b>111 Penn Street</b>  |                         |   |  |  |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>3/21/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co Md</b> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F/H 1101 E. North Ave</b>  |                         |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                        |   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is assigned to the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and attach them to the permit. The permit should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other trauma, a written medical opinion must be completed and attached to this certificate.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROCKSELL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 26, 1981</b> |   |  | 2b. HOUR<br><b>1:07AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 4 27</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Counts</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maddie Miles</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-20-8413</b>   |  | 17. INFORMANT ADDRESS<br><b>Lucy Barksdale 1724 N. Barn St.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>infractable hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardiomyopathy, and valvular disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr</b><br><b>2 1/2 month</b><br><b>unknown</b>  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 23, 1981</b> , to <b>March 26, 1981</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>March 26, 1981</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>LW Martin</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/24/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LW Martin</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/1/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1981</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |  |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>CHARLES WILLIAM CRAWFORD   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3- 3- 1981                          |  | 2b. HOUR<br>M   |  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 -16- 1924   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                    |   |  |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HYV EQUIPT OPER MD. SLAG CO |   | 15. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES W. CRAWFORD, SR  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BEATRICE DIGGS            |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>WW II  |  | 17. INFORMANT<br>ADDRESS<br>DOROTHY R. CRAWFORD 2818 W. MOSHER ST  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronaryopathy</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> 19 <u>80</u> to <u>3/3</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Stanley Morrison</u>  |  |  |  |  | DEGREE   |  |   | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY MORRISON  |  |  |  |  | 22e. ADDRESS<br>M.D. 11 E. CHASE STREET                                    |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>3-7-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MARYLAND NAT MEM PK LAUREL, MARYLAND |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HERBERT E. NUTTER 3035-37 W. NORTH AVE   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981                                |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Raymond M. [Signature]</u>        |  |  |  |



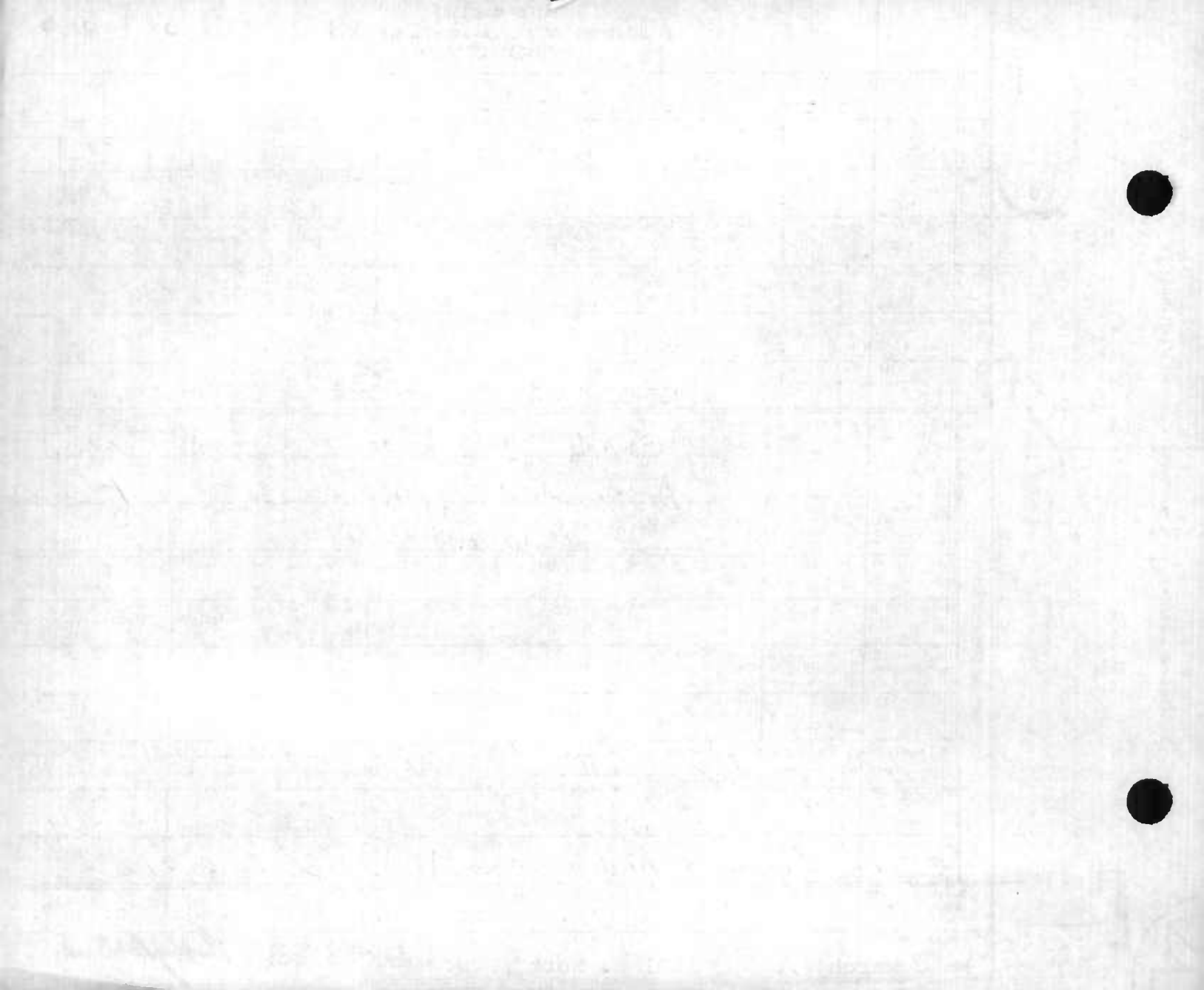
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  | 8 1 0 6 8 6 5                                |   |
|---|--|--|--|--|--|---|
| 1- FOR STATE REGISTRAR  |  |  |  |  | CERTIFICATE OF DEATH                         |   |
| I. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH                            |   |
| Milton T. Crawford  |  |  |  |  | 3 12 81                                      |   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |
| Male  |  | Black  |  | 11 4 24  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |   |
| Md.   |  | USA  |  | 56 YRS.  |  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |
| Balto.  |  | 1609 Biddle Street   |  | Baltimore City MD.   |  |   |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |   |
| Md.   |  |  |  | Balto.   |  |   |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| Benjamin F. Crawford  |  | Celia E. Collins   |  | 13e. STREET ADDRESS  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |
| No  |  | 215-12-9643  |  | Ruth Crawford 1609 Biddle St.  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |
| IMMEDIATE CAUSE (a) <u>Probable Acute myocardial infarction</u>   |  |  |  |  | mins.  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>  |  |  |  |  | 5 yrs  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Permanent CHF</u>   |  |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> 19 <u>81</u> to <u>3/12</u> 19 <u>81</u> that (I) (we) lost <u>saw the deceased alive and above; (I) (we) did not view the body after death.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |   |
| 22b. SIGNATURE <u>E. J. Saunders</u> DEGREE   |  |  |  | 22c. DATE SIGNED <u>3/17/81</u>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elijah Saunders, M.D.</u>  |  |  |  | 22e. ADDRESS <u>2300 Garrison Blvd. 21216</u>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY   |
| Burial  |  | 3/17/81  |  | Mt. Calvary Cem.   |  | Anne Arundel Co., Md.   |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. SIGNATURE  |
| Wm C March F/H  |  |  |  | 1101 E. North Ave.   |  | MAR 16 1981   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>PAULINE A CREWS  |  |   |  | 2b. HOUR P M<br>03 14 81 3.14 P M  |  |   |  |
| 3. SEX<br>Female  |  | 4 RACE<br>Negro   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>03 26 15   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br>65  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South BALTIMORE GENERAL |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Pvt. Family   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS   |  |   |  |
| 13a MD 13b COUNTY 13c BALTIMORE 13d YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e 30 53 Ascension ST.   |  |   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Oscar Hudson   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Amy Parsons  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |   |  | 16b SOCIAL SECURITY NO. 17 INFORMANT ADDRESS<br>218-28-0937- Glenn E. Crews-3053 Ascension St.   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive hemorrhage, left<br>4415<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Ruptured sacciform aneurysm arter<br>(c) Anterior massive<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 03/14 19 81 to 03/14 19 81, that (I) (we) lost saw the deceased alive on 03/14 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b SIGNATURE DEGREE<br>Miguel Fleischman   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c DATE SIGNED<br>03/14/81   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Miguel Fleischman   |  |   |  | 22e ADDRESS<br>South BALTIMORE GENERAL Hospo.  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>3/20/1981   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24 FUNERAL DIRECTOR NAME<br>Herbert E. Nutter-3035 W. North Ave.  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 19 1981  |  | 25b REGISTRAR'S SIGNATURE<br>Ruthy Nutter   |  |





*Handwritten signature*

MAR 1 2 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 6 7   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ida A. Cromwell  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 12 81  |  | 2b. HOUR<br>1455 M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 30, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conard Ernst   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amelia Kihn  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213 74 1338   |  | 17. INFORMANT<br>ADDRESS<br>Roughley L. Porter, Balto., Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6 Mar</u> , 19 <u>81</u> , to <u>12 Mar</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>12 Mar</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we) (did) (did not) view the body after death.               |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Aubrey D. Richardson, M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>12 Mar 1981  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Aubrey D. Richardson, M.D.  |  |   |  | 22e. ADDRESS<br>Keswick Nursing Home, Balto., Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/14/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Aubrey D. Richardson</u>  |  |

4505 York Rd., Balto., Md. 21212  
Henry W. Jenkins & Sons Co.

Burial 2-14-81 London Park

Balto., Md.

Audrey D. Richardson, M.D. Keawick Nursing Home, Balto., Md.

No

212 74 1308

Roughay I. Porter, Balto., Md.

Continued

Ernest

Amelia

Kith

2011 Canterbury Road

Baltimore \*

Honorable Own Home

Keawick Nursing Home

Baltimore

USA

x

Baltimore District

Family

Unit

212 74 1308

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8  | 1 | 0   | 6 | 8  | 6 | 8                        |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|---|---|---|--|---|--------------------------|------|--------------------------------|-----|---|----------|-----------------|--|-----|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | REG. NO.   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Joseph</i>   |  |  |  |  |  |  |  |  |  | FIRST  |   | MIDDLE  |   | LAST   |   | 2a. DATE OF DEATH        |      | MONTH                          | DAY | YEAR  | 2b. HOUR |                 |  |     |  |  |  |  |  |
| 3 SEX <i>Male</i>  |  |  |  |  |  |  |  |  |  | 4 RACE <i>Caucasion</i>  |   | 5. DATE OF BIRTH  |   | MONTH  |   | DAY                      | YEAR | 6 AGE (IN YEARS LAST BIRTHDAY) |     | IF UNDER 1 YEAR   |          | IF UNDER 24 HRS |  |     |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 80   |   | YRS.                     |      | MONTHS                         |     | DAYS  |          | HOURS           |  | MIN |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hospital</i>   |   |   |   |  |   |                          |      |                                |     | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. |          |                 |  |     |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 13a. STATE <i>Md</i>   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <i>Baltimore</i>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS      |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | FIRST  |   | MIDDLE  |   | LAST   |   | 15. MOTHER'S MAIDEN NAME |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>220-18-6550</i>  |   | 17 INFORMANT <i>Lafayette Nursing Center</i> ADDRESS <i>Medical Records 140 Lafayette St., Balt., Md</i>  |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i>  |  |  |  |  |  |  |  |  |  |  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 4599 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Vascular Insufficiency</i>  |  |  |  |  |  |  |  |  |  |  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  | <i>Significant Multiple Atherosclerotic Ulcerations</i>  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 19a. DATE OF OPERATION <i>none</i>   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 22</i> 19 <i>81</i> to <i>March 9</i> 19 <i>81</i> that (I) (we) last saw the deceased alive on <i>March 9</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE <i>L. A. Rock</i> M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <i>3/9/81</i> |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Linda A. Rock</i>   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <i>2600 Liberty Heights Ave Balt., Md.</i>  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>   |  |  |  |  |  |  |  |  |  | 23b. DATE <i>3-11-81</i>   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>Anatomy Board of Md.</i>  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>MAR 16 1981</i>   |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <i>Robert M. ...</i>  |  |  |  |  |  |  |  |  |  |  |   |   |   |  |   |                          |      |                                |     |   |          |                 |  |     |  |  |  |  |  |

1981

Medical records and laboratory tests

Delaware Nursing Center

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

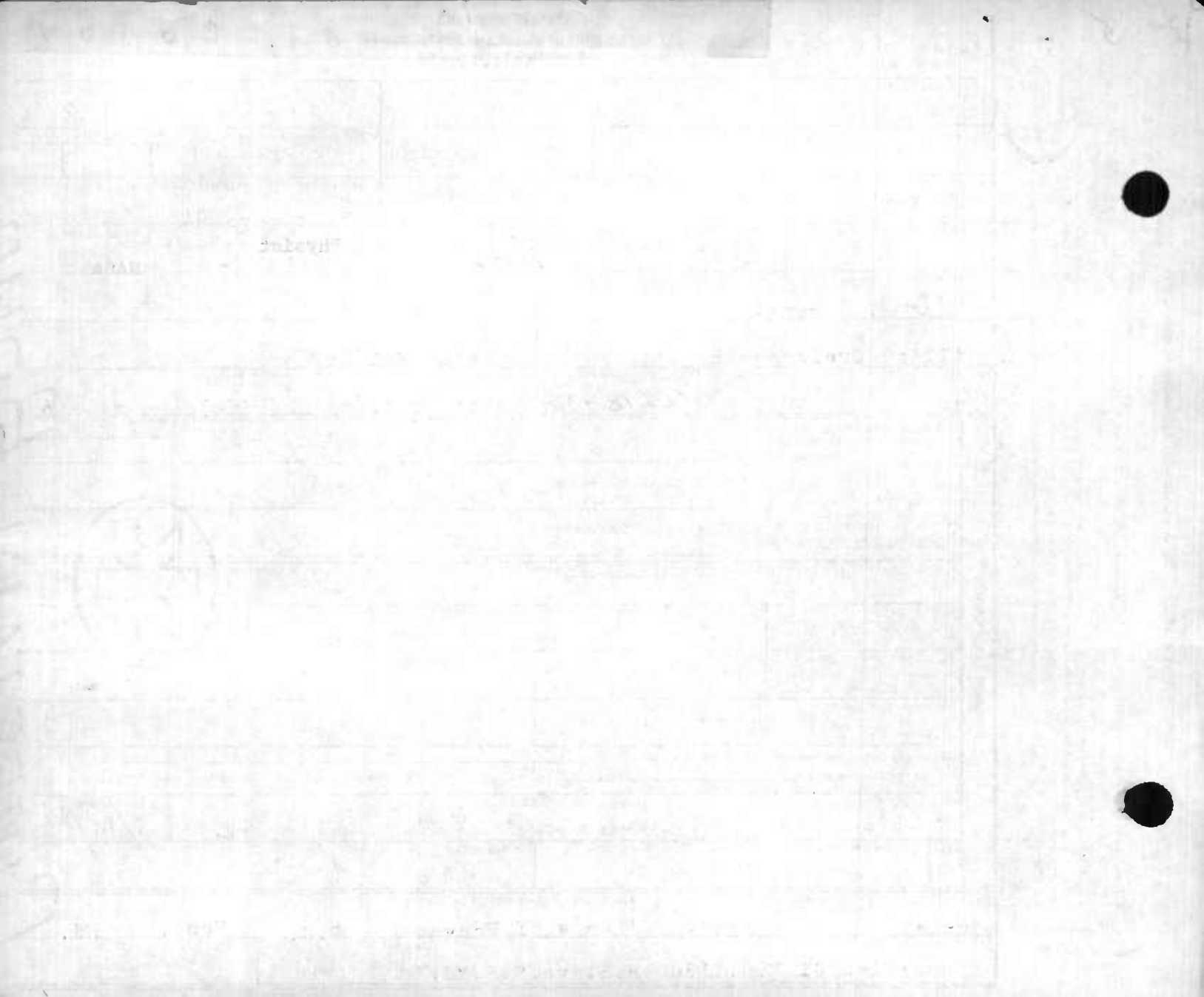
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM CRUICKSHANK</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/18/81</b>   |   | 2b. HOUR<br><b>11 15 P M</b>   |   |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 24 27</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR NATURE OF WORKING LIFE)<br><b>Physician</b>                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NASA</b>                                     |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |   |
| 13a. STATE<br><b>MD.</b>   | 13b. COUNTY<br><b>Mont.</b>   | 13c. CITY OR TOWN<br><b>OLNEY</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>3349 BUENCKE CT</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Cruickshank</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Miller</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>122 18 4369</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Faith Cruickshank (Wife) Same as above</b>            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>3960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>VASCULAR HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MILK AND ALCOHOLIC LIVER DISEASE</b>       |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (6)  |   |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>3/18/81</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>VASCULAR HEART DS.</b>   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/13/81</b> , 19____, to <b>3/18/81</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Robert Applebaum MD</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/18/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT APPLEBAUM</b>   |   | 22e. ADDRESS<br><b>UNIV HOSP</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/23/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>S.S. Mont. Md.</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>  |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. McHenry</b>  |   |  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

06870

|  |                  |   |   |   |  |  |  |   |  |
|--|------------------|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James A. Curtis   |                  |   |   | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>3 20 1981  |  |  |  | 2b. HOUR<br>9 AM  |  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 19 23   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>58 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED<br>DEAD<br>3 20 1981   |  | 2d. HOUR<br>9 AM  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>904 N. Charles Street |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 2006 Park Avenue |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Curtis Sr.  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Ross  |   |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br>216-16-3291   |  | 17. INFORMANT<br>ADDRESS<br>Margaret E. Johnson 452 Watty Ct.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple stab wounds<br>9666<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>XPM 3 20 1981  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject stabbed  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>restaurant   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>904 N. Charles St. Balto. MD.  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |   |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  | TITLE (SPECIFY)<br>M.D. Assistant   |   |   |  | MEDICAL EXAMINER   |  | DATE SIGNED<br>3/20/81  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                  | ADDRESS<br>111 Penn St. Balto., MD.   |   |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>3/23/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville MD.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>WM.C. MARCH F/H INC. 1101 E. North Ave.  |                  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |





*Handwritten signature or mark.*

1881 2 S RAM



TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHM-16 25M  
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 81 06871   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 3-17-81  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn Dabney  |  |   |  | 2b. HOUR 5 A.M.   |  |   |  |
| 3 SEX Female  |  | 4 RACE Black  |  | 5 DATE OF BIRTH MONTH DAY YEAR 2 28 24  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore   |  | 13e. STREET ADDRESS 1702 N. Broadway  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Arthur Craihe  |  |   |  | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Mable Moore  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 242-36-1032  |  | 17 INFORMANT ADDRESS Yvonne O. Robbins 252 Dahlia St. Fairfield Calif.  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio pulmonary arrest   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Ca of breast   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7-81, to 3-17-81, that (I) (we) last saw the deceased alive on 3-17-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE Howardos   |  |   |  | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED 3-17-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss   |  |   |  | 22e. ADDRESS Provident Hosp.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 3/24/81   |  | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Gastonia N.C.   |  |
| 24 FUNERAL DIRECTOR NAME WM.C. MARCH F/H INC. ADDRESS 1101 E. North Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 20 1981  |  |   |  |

MAR 20 1981

25b. REGISTRAR'S SIGNATURE [Signature]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 7 2

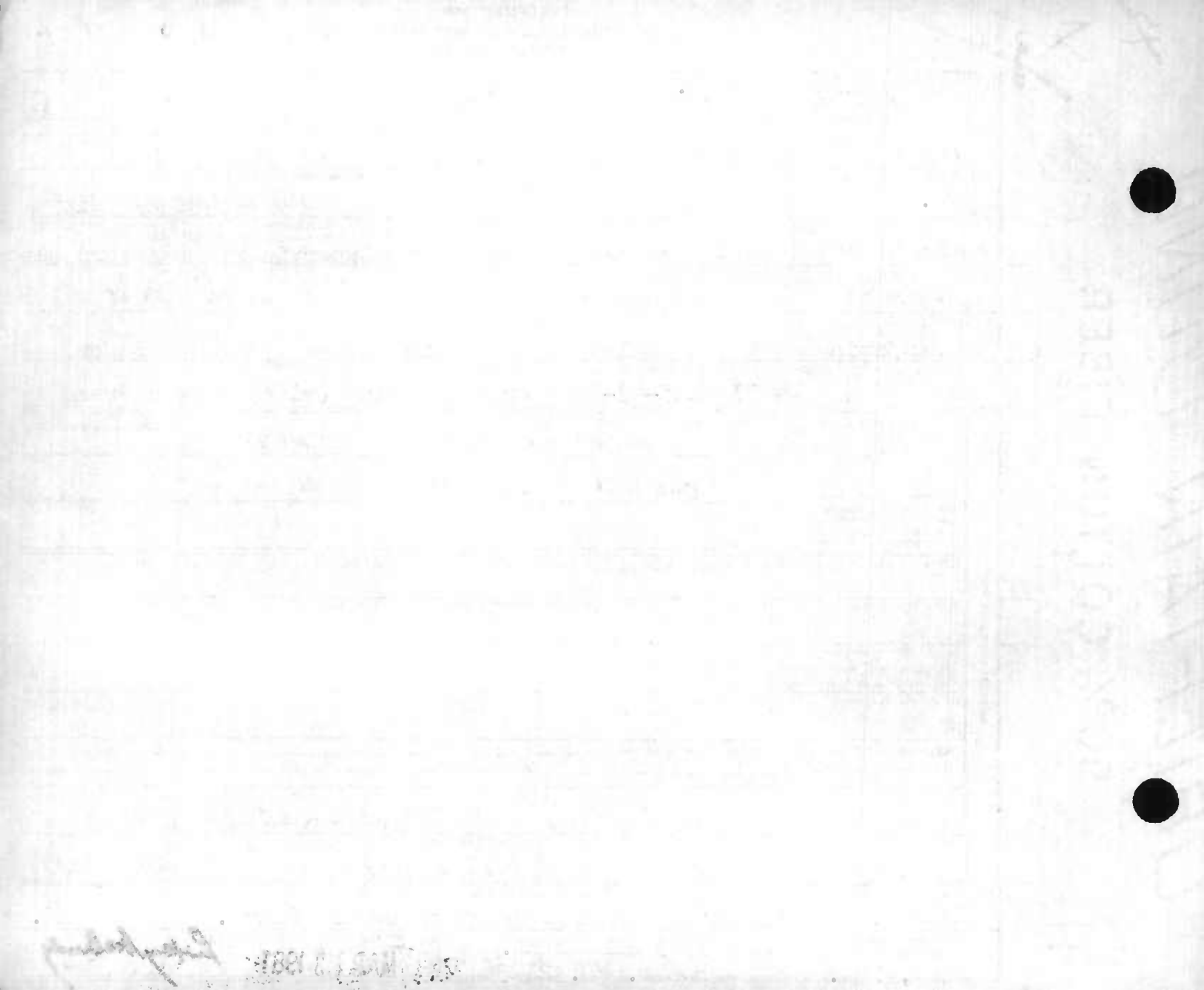
REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Franklin W. DALEY</b>  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 12 1981</b>  |   | 2b. HOUR<br><b>3.35 AM</b>  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 27 19</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61 1/2</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec</b> |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>BALTO.</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Benjamin DALEY</b>  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Bauer</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>WW 11 215-03-9687</b>  |   | 17. INFORMANT ADDRESS<br><b>Frances Daley (wife) same address</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Old cell carcinoma of the lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>L. C. CUEVO M.D.</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>3/12/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEONUINA L. CUEVO</b>   |   | 22e. ADDRESS<br><b>8422 AVERY ROAD BALTO. MD.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/14/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Balto.</b>                       |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR RD. BALTO. MD. 21236</b>  |   |   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. REG. NO.   |  | 8. 1   |  | 0   |  | 6 8 7 3  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Leona Popera Daniecki</b>   |  |   |  | 2a. DATE OF DEATH<br><b>March 31, 1981</b>   |  |   |  | 2b. HOUR<br><b>12:45 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 24, 1930</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS.                                 |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>50</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>U.S. Public Health Service Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>3a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Popera</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Szczepkowski</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220 24 6579</b>  |  | 17. INFORMANT ADDRESS<br><b>U.S.P.H.S. medical records Daniel Daniecki</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>possible brain metastases, cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>lung cancer metastases from lung cancer</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 29, 1981</b> , to <b>March 31, 1981</b> , that (I) (we) last saw the deceased alive on <b>March 31, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Forante Austria, M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3/31/81</b>   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Forante Austria, M.D.</b>  |  |   |  | 23b. ADDRESS<br><b>U.S.P.H.S. Hospital, 3100 Wyman Park Drive Baltimore, Maryland 21211</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/3/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Md.</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. E. Lowell Lemmon</b>   |  |   |  | ADDRESS<br><b>10. W. Padonia Rd.</b>   |  | 25a. DATE OF RECORD<br><b>APR 03 1981</b>   |  | 25b. RECORDING<br><b>John Daniecki</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |  |  |
|---|--|--|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO. 8106874  |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| LEDRA L. DANIEL   |  |  |   |  |  | MONTH DAY YEAR   |   | 3 16 81 6:30 AM  |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR  |  |
| FEMALE  |  | CAUCASIAN  |   | MONTH DAY YEAR   |  | 78 YRS.  |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Nebraska  |  | U.S.A.   |   |  |  | Baltimore City MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | South Baltimore Gen. Hosp.   |   |  |  | Housewife  |   | Own Home   |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland  |  |  | P.G.  |  | Riverdale  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 13e. STREET ADDRESS  |   |  |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST   |  |  | 6000 Quintanna Street  |   |  |  |
| William B. Fuller   |  |  | Lola M. Putnam  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |  |
| No  |  |  | 577-64-1780   |  | Charles E. Daniel, Jr. Address Same as No# 13e.                                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)   |  |  |   |  |  |  |   |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) Pulmonary atelectasis, bilateral, severe  |  |  |   |  |  |  |   |  |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomegaly, marked  |  |  |   |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Acute (healing) myocardial infarction, lt. ventricle            |  |  |   |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis                                  |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-8, 1981, to 3-16, 1981, that (I) (we) lost   |  |  |   |  |  |  |   |  |  |
| saw the deceased alive on 3/16/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| Dr. H. Silva  |  |  |   |  |  |  |   | 3/16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |  |   |  |  |
| Dr. H. Silva  |  |  | South Baltimore General Hospital                                    |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |
| Burial  |  |  | 3-19-81   |  | Ft. Lincoln Cemetery   |  | CITY OR TOWN COUNTY STATE   |  |  |
|   |  |  |   |  |  |  | Brentwood P.G. Md.  |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE RECEIVED BY REGISTRAR                                     |  |  |  |   |  |  |
| NAME ADDRESS  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md.  |  |  | MAR 18 1981   |  |  |  |   |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |  |   |   |   |   |                                   | REG. NO. 06875   |  |
|---|-------------------------|--|--|--|---|---|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Alford (ALFRED) J. DANIELS</b>  |                         |  |  |  |   |   |   |   |                                   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3-1-81</b> |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 21 28</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52 YRS.</b>                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br><b>52 YRS.</b>  |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3-1-81</b>   |   | 2d. HOUR<br><b>8:58</b>           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>      |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1807 Barclay Street</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>BALTO</b>                          |  | 13c. CITY OR TOWN<br><b>Longgreen</b>                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>12538 Manor Rd.</b>                                       |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert B. Daniels</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary R. Thomas</b> |   |   |   |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | (IF YES, GIVE WAR OR DATES)                          |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |   |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |  |  |  |   |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |  |  |   |   |   |   |                                   |  |  |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |  |  |   |   |   |   |                                   |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>  |                         |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER              |   |   |   | DATE SIGNED <b>3-1-81</b>   |                                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |                         |  |  | ADDRESS <b>111 Penn Street</b>   |   |   |   |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3/4/81</b>                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion AME Ch</b>           |   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Longgreen, Md.</b>                 |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H 1101 E. North Ave.</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1981</b>                     |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |                                   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 3.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                    |  |   |  | REG. NO.   |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Linwood NMI Daniels</u>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>03/21/81</u>   |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>Black</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>9 19 34</u>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>46</u> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> MD.   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore</u>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u>  |  |
| 12. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   |  | 13. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Unemployed</u>  |  | 14. KIND OF BUSINESS OR INDUSTRY   |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><u>md.</u> |  | 15b. COUNTY<br><u>Balt. city</u>  |  | 15c. CITY OR TOWN<br><u>Baltimore</u>  |  |
| 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 17. STREET ADDRESS<br><u>1423 N Wolfe St.</u>   |  | 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Charlie Daniels</u>   |  |
| 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mary Mason</u>  |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>  |  | 21. SOCIAL SECURITY NO.<br><u>213325616</u>  |  |
| 22. INFORMANT<br><u>Mary Daniels</u>  |  | 23. ADDRESS<br><u>1423 N. Wolfe St.</u>   |  | 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4210</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>Staphylococcal Endocarditis</u>   |  |
| 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>35 minutes</u>   |  | 26. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>1 month</u> |  | 27. MEDICAL CERTIFICATION<br>19a. DATE OF OPERATION<br>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/><br>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/><br>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19<br>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK<br>21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>81</u> , to <u>3/21</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3/21/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.<br>22b. SIGNATURE<br><u>Lawrence Goldkind</u><br>22c. DATE SIGNED<br><u>3/21/81</u><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Lawrence Goldkind</u><br>22e. ADDRESS<br><u>22 S. Greene St.</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>3/26/81</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Auburn Cem.</u>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore</u> <u>MD</u>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/H</u>   |  | 25. DATE REC'D. BY REGISTRAR<br><u>MAR 23 1981</u>   |  |
| 26. ADDRESS<br><u>1101 E. North Ave.</u>  |  | 27. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  | 28. [Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8106877  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA J. DANIELS</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/25/81</b>   |  | 2b. HOUR<br>M  |  |
| 3 SEX<br><b>Fe</b>   |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/2/1915</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b><br>YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b><br>MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sugar Refinery</b>   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Langley</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Hardy</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214 12 8363</b>   |  | 17 INFORMANT ADDRESS<br><b>Mr. Samuel Daniels 1805 Edmondson Avenue</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Suspect: Ventricular Tachycardia (from previous history)</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> , 19 <b>75</b> , to <b>3-12</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3-12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Angela Adams MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-26-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANGELITA TOPANO, MD</b>  |  |   |  | 22e. ADDRESS<br><b>2502 Eutaw Pl. Balto MD 21217</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>3/30/81 Burial</b>  |  | 23b. DATE<br><b>3/30/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Md</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons</b>  |  |   |  | ADDRESS<br><b>1701 Laurens St.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

*Handwritten signature*

FROM D. E. HOLM

30 APR 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRVINE</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-12-81</b>         |   |  | 2b HOUR<br><b>830 P.M.</b>   |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 22, 1920</b>                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b>  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                               |  |  |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>            |  | 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>                    |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OFFICE MANAGER</b> |  |  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>  |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>2604 WHITNEY AVE. #21215</b>                                    |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISRAEL</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA</b>   |   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR NAVY)<br><b>WWII-ARMY 215-12-8577</b> |  |  |
| 17 INFORMANT<br><b>MRS. HANNAH DANSICKER</b>  |  |   | ADDRESS<br><b>2604 WHITNEY AVE. BALTO., MD 21215</b>         |   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Coronary</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                       |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   | DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD, previous MI</b> |   |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b>   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Neuropathic ulceration 2- to 3-cm to 4-cm ADENOMA</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>1973</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Prostatectomy</b> |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>        |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1964</b> 19____, to <b>3/12/81</b> 19____, that (I) (we) last saw the deceased alive on <b>12/22/80</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><b>Joseph Shear M.D.</b>   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |  |  |  | 22c DATE SIGNED<br><b>3/13/81</b>  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH SHEAR</b>   |  |   |  | 22e ADDRESS<br><b>6715 PARK HTS. AVE. BALTO., MD 21215</b>                          |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b DATE<br><b>3/15/81</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>                            |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>                                  |  | 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 7 9

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |      |  |     |  |                  |
|--|--|---|--|---|--|---|--|--|------|--|-----|--|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Henry</b>   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |      | MONTH                                  | DAY | YEAR   | 2b. HOUR         |
|  |  |   |  |   |  | <b>Dates</b>  |  |  |      |  |     | <b>3 1 81</b>                                | <b>8:20 P.M.</b> |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>Black N</b>   |  | 5. DATE OF BIRTH  |  | MONTH   |  | DAY  | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY)        |     | # UNDER 1 YEAR                               |                  |
|  |  |   |  | <b>10 04 63</b>   |  |   |  |  |      | <b>78 77</b>                           |     | YRS. MONTHS DAYS HOURS MIN.                  |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b>                                      |  |  |      |  |     | MD.  |                  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |      |  |     |  |                  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1213 Light St.</b>   |      |  |     |  |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joshua Dates</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No W.W.K.</b>  |  | 16b. SOCIAL SECURITY NO<br><b>217-01-06</b>   |  | 17. INFORMANT<br><b>Mrs. Margaret Dates</b>  |      | ADDRESS<br><b>2406 Winchester Ave.</b> |     |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>5070</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Possible Septic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aspiration Pneumonia</b>                  |  |   |  |   |  |   |  |  |      |  |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Chronic Renal Failure</b>  |  |   |  |   |  |   |  |  |      |  |     |  |                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |  |     |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |      |  |     |  |                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |      |  |     |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-19</b> , 19 <b>81</b> , to <b>3-1</b> , 19 <b>81</b> , that (I) (we) <input checked="" type="checkbox"/> host saw the deceased alive on <b>3-1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> did (did not) view the body after death. |  |   |  |   |  |   |  |  |      |  |     |  |                  |
| 22b. SIGNATURE<br><b>Dr. M. Jones</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3-1-81</b>   |  |  |      |  |     |  |                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. M. Jones</b>   |  | 22e. ADDRESS<br><b>South Balto. General Hosp.</b>   |  |   |  |   |  |  |      |  |     |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/5/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>                                |  |  |      |  |     |  |                  |
| 24. FUNERAL DIRECTOR<br><b>LeRoy O. Dyett</b>  |  | 4600 Liberty Heights Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Jones</b>  |  |  |      |  |     |  |                  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) <b>Benjamin DAVIS</b>  |  |   |  | MONTH <b>3</b> DAY <b>30</b> YEAR <b>81</b>   |  | 2b. HOUR <b>4:45</b> A.M.   |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>Cauc</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>81</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS   |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>Balto City</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13f. STREET ADDRESS <b>817 St. Paul St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Wilson</b> MIDDLE <b>L</b> LAST <b>DAVIS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Florinda</b> MIDDLE <b>Mowery</b> LAST <b>Mowery</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK.</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>297-12-5190</b>   |  | 17. INFORMANT ADDRESS   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulm Arrest</b><br><b>5789</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>GI Bleed, Resp Distress</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>24 hrs.</b> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>2/20/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute Abdo Perforation of Appendix</b>                          |  | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/30/81</b> , 19 <b>81</b> , to <b>3/30</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.      |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Roy S. Moore MD</b> DEGREE   |  |   |  | 22c. DATE SIGNED <b>3/30/81</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S MOO T</b>  |  |
| 22e. ADDRESS <b>Mercy Hosp. St. Paul St Balto.</b>   |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |  | 23b. DATE <b>4/6/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto... Md.</b>  |  |   |  | 24b. DATE RECEIVED BY REGISTRAR <b>APR 10 1981</b>  |  |   |  |
| 24c. REGISTRAR'S SIGNATURE <b>P. J. Kelly</b>  |  |   |  | 24d. REGISTRAR'S SIGNATURE  |  |   |  |

MEDICAL CERTIFICATION

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History Board

Patco, Inc.

Removal

0/5/81

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11/11/01 BY 60322 UCBAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon #2 and #3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHERYL L. DAVIS</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 08, 1981</b>                                    |  | 2b. HOUR<br><b>06:38AM</b>  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 17 58</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1833 Aisquith St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James H. Davis</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Green</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-70-0972</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Dora Davis 1833 Aisquith St.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br>5/30 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>overwhelming pneumonia</b> }<br>(c) <b>lung cancer</b> }<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |   |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— Baltimore City Md.</b>  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 2, 1981</b> , to <b>March 8, 1981</b> , that (I) (we) most saw the deceased alive on <b>March 8, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>LW Martin</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>March 8, 1981</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LW Martin</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Brady</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

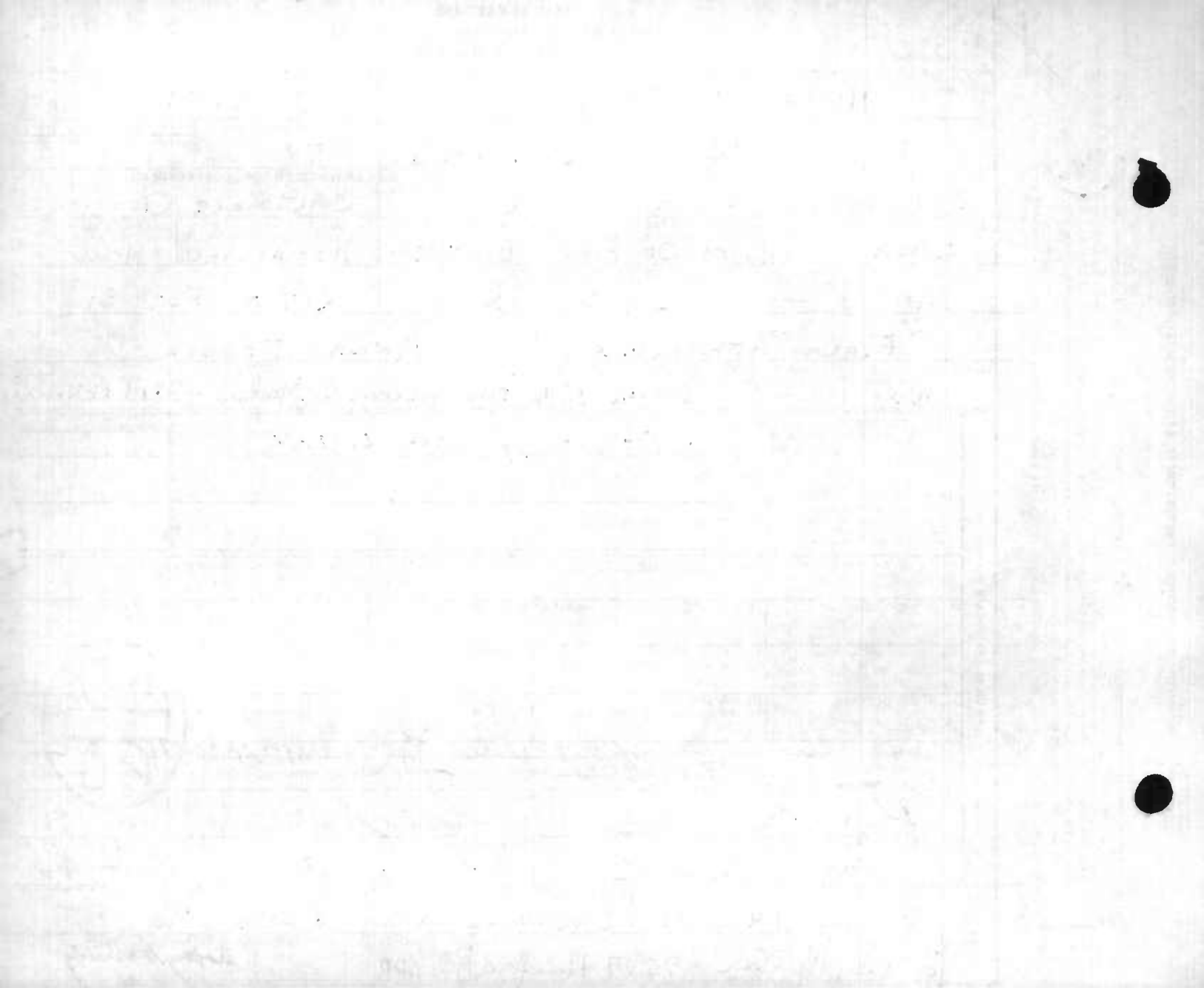
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |   |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HILDA M. DAVIS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-30-81                         |   |  | 2b. HOUR<br>M   |   |  |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>W.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-3-1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HOUSE OF PINES - BELVEDERE |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                        |  |  |
| 13a. STATE<br>MD.  |  |   | 13b. COUNTY<br>—   |   | 13c. CITY OR TOWN<br>BALTO.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>217 N. PORT ST.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK AFFAYROUX  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA FOUSEK   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>—  |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Rebecca C. Malone - 3813 Calodale Ave.  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). CARINOMA OF LUNGS<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (the physician) attended the deceased from above, (I) (we) (did not) saw the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br>for Sunshine, M. D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/1/81  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. SUNSHINE  |  |   |  |   | 22e. ADDRESS<br>6210 Pk. Hts Ave, Balt, Md.  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>4-3-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE Cem.   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martley Miller   |  |   |  |   | ADDRESS<br>7527 Harford Rd   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 8 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |  |   |  |
|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>marie Davis</i>            |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3-29-81</i>                         |   |   | 2b. HOUR<br><i>1:15 A.M.</i>   |  |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>white</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6-3-99</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>U.S.A.</i>        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. city.</i> MD.                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. Md.</i>                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Federal Hills Nurs. Center</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a. STATE<br><i>md.</i>  |  |   |  |   | 13b. CITY OR TOWN<br><i>Calvert North Beach</i> |  | 13c. STREET ADDRESS<br><i>Annapolis Ave. 801</i> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Walter E. Phares</i> |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lucy Ritchie</i>       |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>       |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>578-14-7654</i>                    |  |   | 17 INFORMANT (Brother) ADDRESS<br><i>W. Byron Phares, 630 Sheridan St.</i> |   |   |  |  |   |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *ACUTE CEREBRAL INFARCTION*

DUE TO, OR AS A CONSEQUENCE OF

(b) *ACUTE CEREBROVASCULAR OCCLUSION*

DUE TO, OR AS A CONSEQUENCE OF

(c) *ATHEROSCLEROTIC CARDIOVASC. DISEASE*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*CHRONIC BRAIN SYNDROME - SEIZURE DISORDER*

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>6/1/80</i> to <i>3/29/81</i> , that (1) (two) last saw the deceased alive on <i>3/1/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |

|  |  |   |  |                                      |  |
|--|--|---|--|--------------------------------------|--|
| 22. SIGNATURE<br><i>Joseph D. Notarangelo M.D.</i>                         |  | DEGREE<br><i>M.D.</i>                                 |  | 22c. DATE SIGNED<br><i>3/29/1981</i> |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JOSEPH D. NOTARANGELO M.D.</i> |  | 22a. ADDRESS<br><i>301 ST. PAUL PLACE BALTO 21202</i> |  |                                      |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                              |  | 23b. DATE<br><i>4/2/81</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Pleasant Church</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Cemetery Harrisonburg, Va.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</i> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 1 1981</i>               |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 8 8 4  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |   |  |
| FIRST MIDDLE LAST<br><b>ROLAND MARVIN DAVIS</b>  |  |  |  | MONTH DAY YEAR<br><b>3 13 81</b>  |  |  |  | <b>7:15a</b>   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 26</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>             |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1746n MORELAND AVENUE 21216</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROLAND DAVIS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH DAVIS</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW11 269-20-8802</b>   |  | 17. INFORMANT ADDRESS<br><b>Eula Davis 1009 Poplar Grove St. Wife</b>          |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bilateral Bronchopneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Squamous Carcinoma of lung</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos</b> |  |  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Granulocytopenia, Acute Renal Failure</b>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 7 81</b> , to <b>MARCH 13 81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 13 19 81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.  |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Howard Freeland MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/13/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard Freeland MD</b>   |  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  |  | 23b. DATE<br><b>3/17/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. park</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>C. Wainwright</b> ADDRESS <b>2700 Edmondson Ave.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

1947 18 12 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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1947 18 12 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

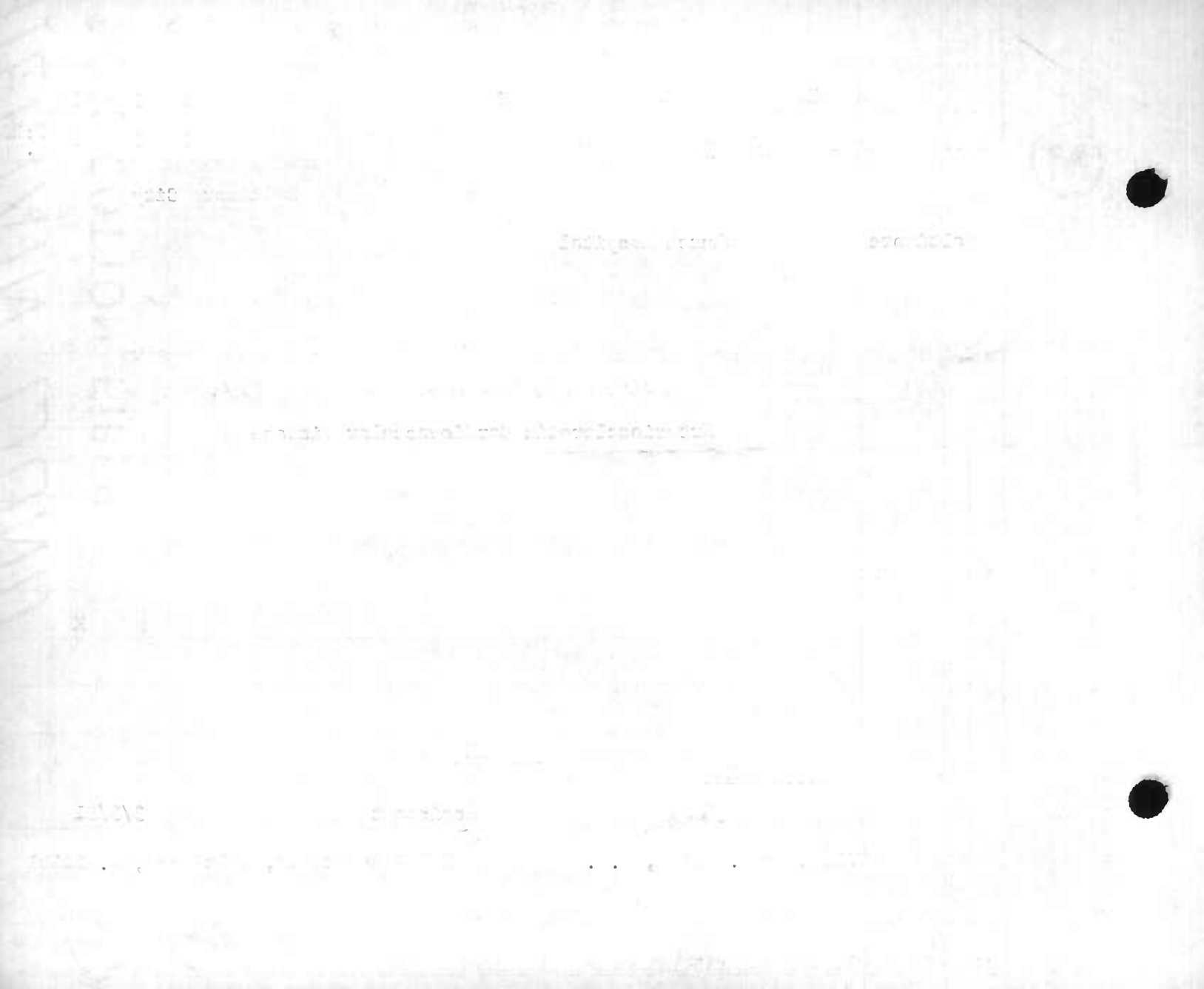
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |   |  |  |                             |
|---|--|--|--|---|--|---|---|--|--|-----------------------------|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |   |  |  |                             |
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |   |   |  |  |                             |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Willie R. Davis</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 21 81</b>   |   |   |  |  | 2b. HOUR<br><b>315 A.M.</b> |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 24 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ga</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.               |   |  |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |                             |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |  | 13e. STREET ADDRESS         |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13e. STREET ADDRESS<br><b>1921 W. Baltimore Street</b>                          |   |  |  |                             |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Rob Davis</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sis ???</b>                                 |   |   |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220 24 8532</b>   |  | 17. INFORMANT ADDRESS<br><b>Bernice Lucas 1921 W. Baltimore Street</b>  |  |   |   |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>5990</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>UTI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CVA</b> |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |                             |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |   |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>81</b> , to <b>3/21/81</b> , 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |  |                             |
| 22b. SIGNATURE<br><b>Edward P. Kozak</b> M.D.   |  |  |  |   | 22c. DATE SIGNED<br><b>3/21/81</b>   |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDWARD P. KOZAK</b>  |  |                             |
| 22e. ADDRESS<br><b>LUTHERAN HOSP.</b>   |  |  |  |   |  |   |   |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>327 81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>                  |   |  |  |                             |
| 24. FUNERAL DIRECTOR NAME<br><b>Brown/Thompson F.H.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Barney Helms</b>   |  |  |                             |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>1913 W. Baltimore St</b>   |  |  |  |   |  |   |   |  |  |                             |

[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 06886   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>AMELIA</b>  |  |  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  | 2c. DATE OF DEATH  |  |
| 3. SEX <b>Female</b>  |  |  |  |  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| 13a. STATE <b>MD</b>  |  |  |  |  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS <b>214 N. Milton Ave</b>               |  |
| 14. FATHER'S NAME   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.<br><b>Obesity</b>   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  | ACTUAL SIGNATURE <b>Virginia L. Dolan</b> M.D.   |  | TITLE (SPECIFY) <b>Assistant</b>   |  | DATE SIGNED <b>3/3/81</b>                                  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |  |  |  |  |  | ADDRESS <b>111 Penn Street, Baltimore, Md. 21201</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>MARCH 6, 1981</b>                             |  |
| 24. FUNERAL DIRECTOR NAME <b>Hartley Miller Funeral Home</b>  |  |  |  |  |  | ADDRESS <b>2334 Jefferson St</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>              |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Marie E. Day</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 15 1981</b>  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 9 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  | 2b. HOUR<br><b>3:15P</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b>                                |  | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO, MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Mgr.-Ret.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tire Sales</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>   |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>      |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George EDWARD HERR</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL I. OLDFIELD</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-3967</b>  |   | 17. INFORMANT ADDRESS<br><b>Renee Nash (Dau.) 8129 S.W. 81st St. Miami, Fla. 33143</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>3352</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>amyotrophic lateral sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-13</b> , 19 <b>81</b> , to <b>3-15</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3-15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lewis</b>  |  |   |  |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>3-15-81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEWIS</b>   |  |   |  |   | 22e. ADDRESS<br><b>900 CATON AVE. BALTO. MD. 21229</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL</b>   |  |   | 23b. DATE<br><b>3-16-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board of Md. Baltimore, Maryland</b>   |  |   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 15 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE                 |  |  |  |

BP

BALTO CITY

ST. AGNES HOSPITAL

BALTO, MD

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 8 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |  |  |
|---|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR H. DECKERT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 30 81</b> |   | 2b. HOUR<br><b>3:17 P.M.</b>  |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 28, 1909</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b>          |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>                     |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Rodgers Forge</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eli Hovis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Levisa Murrin</b>  |   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b> IF YES, GIVE WAR OR DATES |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>467-09-1800A</b>   |  | 17. INFORMANT ADDRESS<br><b>Francis S. Deckert 6820 Pinehurst Rd.</b>  |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL SHUT DOWN</b><br><b>4373</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>BRAIN DEAD DUE TO BRAIN STEM INFARCT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POSTERIOR COMMUNICATING ARTERY ANEURISM</b> |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 a.m. 3/30/81</b><br><b>3/28/81</b><br><b>early in 1981</b>            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>possible rebleeding of the aneurism; of stroke after clipping</b>   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/23/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RIGHT POSTERIOR COMMUNICATING ARTERY</b>  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>81</b> , to <b>3/30</b> , 19 <b>81</b> , that (1) (we) lost<br>saw the deceased alive on <b>2:15 P.M. 3/30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>SoK Bode</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |   | 22c. DATE SIGNED<br><b>3/30/81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGIA K. BODE</b>   |  |  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 2, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Grds.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Bal. Co., Md.</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road, Bal. Md.</b>   |  |  |   | 25a. DAY RECEIVED BY REGISTRAR<br><b>APR 3 1981</b>   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

April 2, 1951 Valley View, N.Y.

April 2, 1951 Valley View, N.Y.

April

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Handwritten notes and markings, including a large 'X' and various illegible scribbles.

Handwritten notes and markings, including the word 'April' and various illegible scribbles.

Handwritten notes and markings, including the word 'April' and various illegible scribbles.

Handwritten notes and markings, including the word 'April' and various illegible scribbles.

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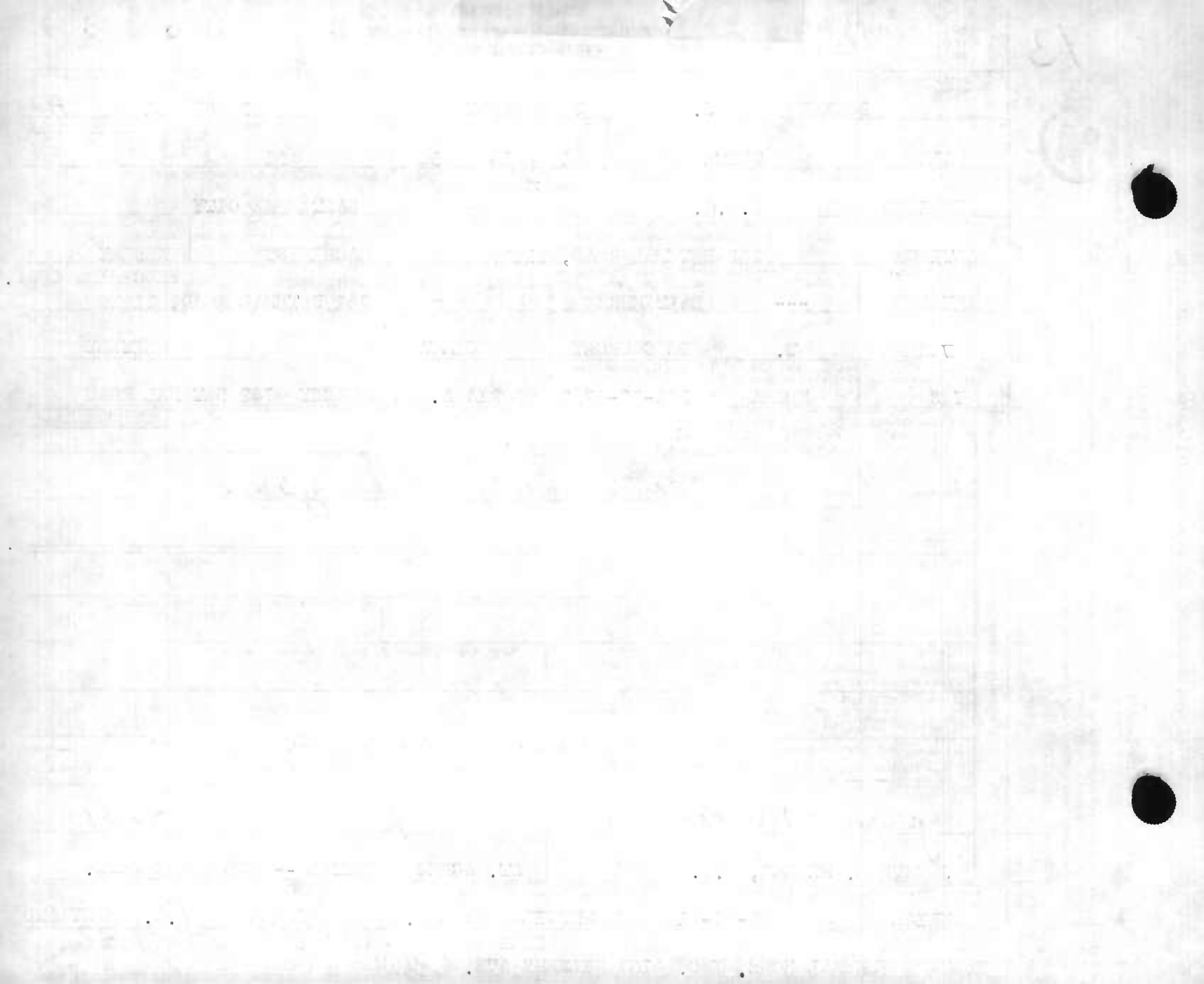
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  | REG. NO.                                    |  |
|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   | 8 1 0 6 3 8 9  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>BERNARD J. DE COURCEY  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 05 81   |   | 2b. HOUR<br>A M  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>01 14 30  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>742 BETHNAL ROAD, 21229 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>KENLEY |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>---  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD T. DE COURCEY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLEVA WHITNEY  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>KOREA 301-22-8752   |   | 17. INFORMANT ADDRESS<br>GLORIA A. DE COURCEY 742 BETHNAL ROAD   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cir pulmonale</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive Pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> 19 <u>74</u> , to <u>February</u> 19 <u>81</u> , that (I) <u>was</u> last saw the deceased alive on <u>2-12</u> 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>will</u> (did) view the body after death.                              |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Joseph H Miller MD</u>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>3/6/81</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOSEPH H. MILLER, M.D.   |  |   |   | 22e. ADDRESS<br>ST. AGNES HOSPITAL -- PULMONARY DEPT.  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>03-09-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CROWNSVILLE VA CEM.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CROWNSVILLE A.A. MARYLAND  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Anthony Kennedy</u>  |  |   |   |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |                                   |  |          |  |
|---|---|---|---|---|-----------------------------------|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH   |   | MONTH   | DAY                               | YEAR   | 2b. HOUR | P<br>M                                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE  | LAST  |                                   |  |          |  |
| Michael   |   | L   | DeFeo   |   |                                   |  |          |  |
| 1. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |                                   | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS                              |
| Male  | White   | February 14, 1914   |   | 67 YRS.   |                                   | MONTHS   |          | OAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |  |          |  |
| Maryland  | U.S.A.  |   |   | Baltimore City  |                                   |  |          | MD.  |
| 10. CITY OR TOWN OF DEATH   | 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |
| Baltimore   | Jenkins Memorial Nursing Home<br>1000 S. Caton Ave. Balt., Md. 21229                        |   | Tailor  |   |                                   |  |          |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |                                   |  |          |  |
| Maryland  |   | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3110 Echodale Ave   |                                   |  |          |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |   |                                   |  |          |  |
| Michael   |   | Lucia   |   | Imperial  |                                   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS   |                                   |  |          |  |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW 11   |   | 213-03-5410   |   | Mr Joseph P DeFeo 2809 Rosalie Ave  |                                   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Tr. infection</u><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Stroke - C.V.D. - Cerebellar Ataxia</u><br>(c) <u>Diabetes Mellitus</u>              |   |   |   |   |                                   |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |   |                                   |  |          |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?           |          |  |
|   |   |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-14-79</u> , 19 <u>81</u> , to <u>3-4-81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-4-81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><u>George Angov</u>   |   | DEGREE<br>ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><u>3-23-81</u>                                       |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>GEORGE ANGOV</u>  |   | 22e. ADDRESS<br><u>3350 Wilkms Pk. - Baltimore</u>  |   |   |                                   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |   | 23b. DATE<br><u>3/25/81</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Mem. Park</u>   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u> |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Leonard J Ruck Inc. Baltimore, Maryland</u>  |   | ADDRESS<br><u>Baltimore, Maryland</u>   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 24 1981</u>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>Rafay McHenry</u>                       |          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



1940

1941

1000 S. Cotton Ave. Bldg. 2122  
Lorraine Memorial Home



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 8 9 1

|  |  |   |  |
|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William F. Dehne, Sr.   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 5, 1981   |  |
| 3. SEX<br>Male   |  | 2b. HOUR<br>8:15a <sub>M</sub>  |  |
| 4. RACE<br>White   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 14, 1922  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Policeman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  |
| 13c. CITY OR TOWN<br>Essex 21221   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>1120 Tace Dr. Apt. 2-A  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George - Dehne   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary - Fischer   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WWII   |  | 16b. SOCIAL SECURITY NO.<br>217 12 0505   |  |
| 17. INFORMANT<br>ADDRESS<br>1578 Harford Square Dr.<br>Edgewood, Maryland 21040  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal failure (hyperkalemia)</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Aortic occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cardiogenic shock (LV aneurysmectomy)</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Coronary artery disease</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs  |  |
| 19a. DATE OF OPERATION<br>3/4/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Coronary artery disease   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br>KIRK KANTER MD  |  |
| 22c. DATE SIGNED<br>3/5/81   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KANTER   |  |
| 22e. ADDRESS<br>Johns Hopkins Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3-7-81   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Brodzinski Funeral Home PA   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981   |  |

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 58554 4/3/81 gj   |  |  |   |  |  |   |  |  |   | STATE OF MARYLAND  |  |   |  |  |  |   |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |   |  |  |   |  |  |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   | REG. NO. 06892   |  |   |  |  |  |   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Carroll Dendy</b>  |  |  |   |  |  |   |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>10</b> YEAR <b>81</b> 2b. HOUR <b>M</b>   |  |   |  |  |  |   |  |  |  |
| 3. SEX<br><b>M</b>   |  |  | 4 RACE<br><b>B</b>  |  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>15</b> YEAR <b>88</b>   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |  |   |  |  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3010 Belmont Avenue</b> |  |  |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>3010 Belmont Ave.</b> |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Tate</b> MIDDLE <b></b> LAST <b>Dendy</b>  |  |  |   |  |  |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emma</b> MIDDLE <b></b> LAST <b></b>  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |   |  |  |   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-05-8959</b>   |  |   | 17. INFORMANT<br>ADDRESS<br><b>Glenton Dendy 3010 Belmont Ave.</b>   |  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Obstructive Pulm. disease.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Alters Sclerotic Cardio Vascular disease.</b>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-19-</b> 19 <b>81</b> to <b>2-27-</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>2-26-</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |   |  |  |   |  |  |   | 22c. DATE SIGNED   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>DARSHAN S. SALUJA</b>   |  |  |   |  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DARSHAN S. SALUJA</b>  |  |  |   |  |  |   |  |  |   | 22e. ADDRESS<br><b>1600 MT Royal Ave, Balto. 21217</b>   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>3/15/81</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |  |   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  |  |   |  |  |   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. H. H. H.</b> |  |  |  |



*[Handwritten signature]*

1987 1-1-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at all times.

4

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |   |   |  |
|---|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEONIE von K. DENMEAD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 81</b>                  |   |  | 2b. HOUR<br><b>7<sup>50</sup> AM</b>   |   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 19, 1886</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4 Upland Road</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Erhard von Knobloch</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha von Cappe</b>  |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212 07 0448</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Charles LeViness, Balto., Md.</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE EMBOLI</b><br><b>4273</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>A FIB</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YRS.</b> |  |   |  |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/24</b> , 19 <b>81</b> , to <b>3/25</b> , 19 <b>81</b> , that (he) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>D. Carroll</b><br>DEGREE<br><b>MD</b>  |  |   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/25/81</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. CARROLL</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>UMH, BALTO., MD.</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>3/27/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |  |   |  |   |  | 25a. FILED<br><b>MAR 26 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |  |

100-200000-1000

Erhard von Knobloch  
Baltimore  
Maryland  
New York  
USA  
Homenaker  
Own Home  
ATLANTA CITY  
Nov. 1, 1964

400 York Road, Baltimore, Md. 21212  
Mary W. Jacobson & Sons Co.  
8127 41st St., Baltimore, Md.  
MAR 6 1967

## MEDICAL CERTIFICATION

DHMH-16 30M 2/80  
(VRA 15, 4)

## 24. FUNERAL DIRECTOR

NAME ADDRESS  
Gerald N. Minnich Hagerstown, Maryland

25a. DATE REC'D, BY REGIS  
MAR 26 1981



1901 - 3AM

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 6 8 9 5   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARISA C. Diseta</b><br><i>Baby Girl</i>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-14-81</b><br>2b. HOUR<br><b>3:30pm</b>  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-12-81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44 yrs. 46 min.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>CHASE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Diseta</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DEBORAH SPAULDING</b>   |  | 13e. STREET ADDRESS<br><b>414 Carroll Island Rd</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>FATHER</b>  |  | ADDRESS<br><b>ABOVE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory distress syndrome and persistent fetal circulation possible hypoplastic lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Prematurity</b> |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Inappropriate ADH Syndrome</b>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Kozue Leone, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/14/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kozue Leone, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>900 CATON AVENUE BALTIMORE MD 21229</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/17/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLT REDEMPTION</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Connelly Funeral Home</b>  |  |   |  | ADDRESS<br><b>300 Mace Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

900 CATON AVENUE BALTIMORE MD 21229

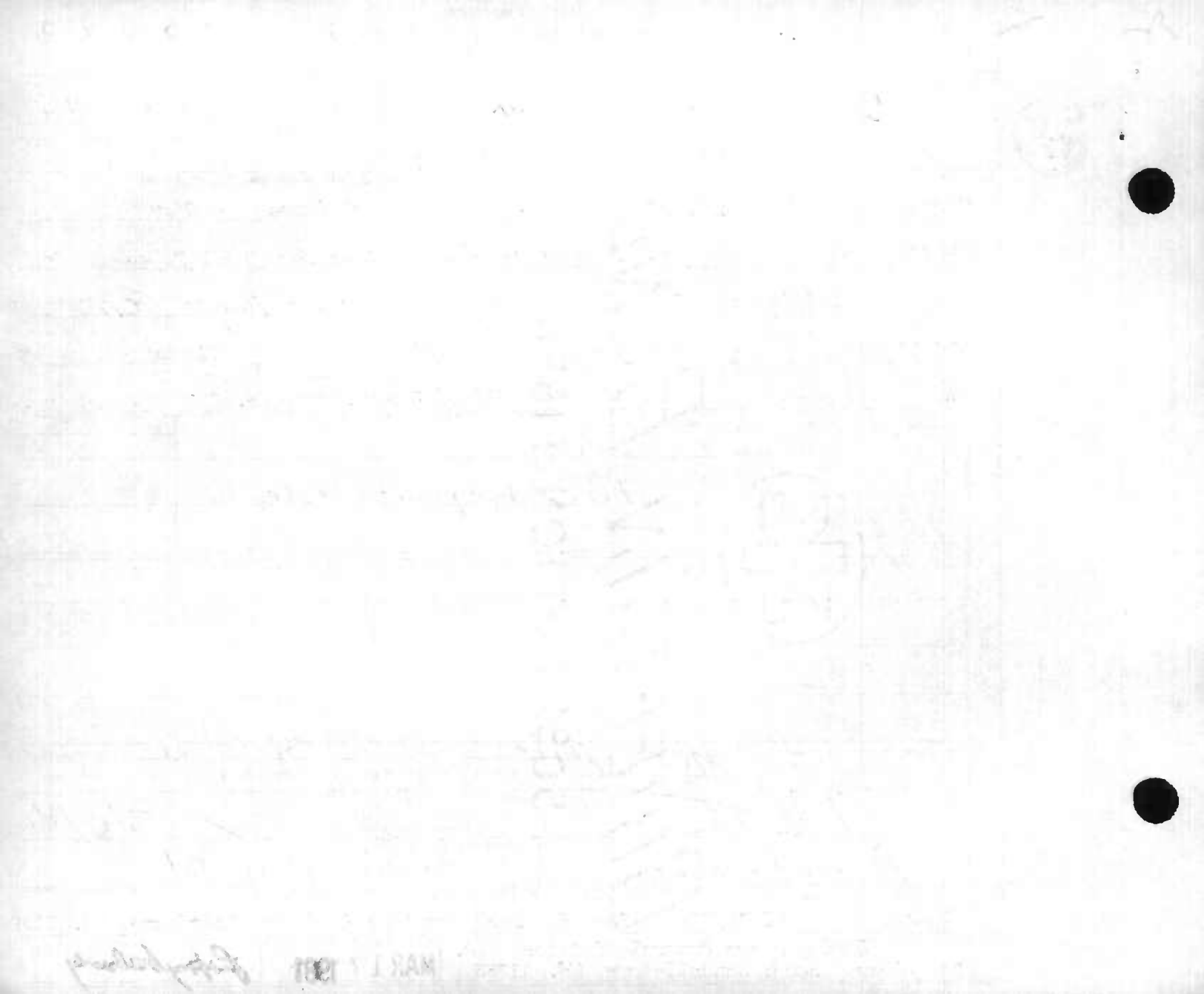
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 8 9 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 20. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br><i>Dolores E. DITMAN</i>  |  |   |  | MONTH DAY YEAR<br><i>3 14 81</i>  |  |  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>W</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 25 09</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>71</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto City</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sinai Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Operator- C &amp; P Telephone Co.</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Md</i>  |  |   |  | 13b. CITY OR TOWN<br><i>Baltimore</i>   |  | 13c. STREET ADDRESS<br><i>1910 Myer Terr 21207</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Phillip Samilton</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sophia Viemeyer</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>218-03-6795A</i>   |  | 17. INFORMANT<br><i>Baltimore, Maryland 21207</i><br><i>Willard Leroy Ditman Jr., 3119 Cresson Ave.,</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Sepsis</i><br><i>2041</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>chronic lymphocytic leukemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/26</i> , 19 <i>81</i> , to <i>3/16</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>3/14/81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>A. Hettelman</i>   |  |   |  | 22e. ADDRESS<br><i>Sinai Hospital</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3/17/81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cemetery Woodlawn, Baltimore, Md.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>21207</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors P.A.</i><br>ADDRESS<br><i>8728 Liberty Road, Randallstown, Md. 21133</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 17 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
| REG. NO.  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DANIEL R DIX</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 28 81</b>   |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  |  |  |  | 4. RACE<br><b>Black</b>  |  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 12 1951</b>  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>30</b> YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| 13a. STATE<br><b>Md</b>   |  |  |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Will Dix</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Clinton</b>   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |
| 17. INFORMANT<br><b>Mary Dix</b>  |  |  |  |  | ADDRESS<br><b>2339 Edmondson Ave.</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>0709</b> DUE TO, OR AS A CONSEQUENCE OF <b>Fulminating Hepatitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One week</b> |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |  |  |  |  |  |  |
| MEDICAL CERTIFICATION   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  |  |  |
| 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>03/23 19 81 to 03/28 19 81</b>  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/27 19 81</b> , to <b>03/28 19 81</b> , that (I) (we) last saw the deceased alive on <b>03/27 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kuang-Yzen Huang</b>   |  |  |  |  | 22c. DATE SIGNED<br><b>03/28/81</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YZEN HUANG</b>  |  |  |  |  | 22e. ADDRESS<br><b>BON Secours Hospital</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>   |  |  |  |  | 23b. DATE<br><b>3-31-81</b>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown/Thompson F.H.</b>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 1 1981</b>   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  | 25c. REGISTRAR'S SIGNATURE   |  |  |  |  |

Brown/Thompson F.H. 1913 W. Baltimore St.



NOV 11 1961  
11:41 AM  
FBI - JACKSON

RECEIVED NOV 11 1961  
FBI - JACKSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  | 8 1 0 6 8 9 8   |   |
|--|--|--|---|--|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |   |  | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Baby Boy Dixon</b>  |  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR<br><b>3-12-1981</b>  |   |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-10-1981</b>                      |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>2</b>       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT IN-SUGGEST FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital Baltimore</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.           |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>0</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>   |  |   |   |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>2402 Loyola Northway Apt 301</b>                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Dixon Jr.</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roslyn Jones</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>0</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>0</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Roslyn Jones Dixon, 2402 Loyola Northway</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypoxia - Acidosis</b><br>7479<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Persistent Fetal Circulation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumothorax + RDS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hour</b><br><b>12 Hours</b> |  |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Prematurity - 26 weeks</b>  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>           |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Jacob K Felix MD</b>  |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-12-81</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jacob K Felix</b>  |  | 22e. ADDRESS<br><b>Sinai Hospital</b>                                  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>Cremated</b>  |  | 23b. DATE<br><b>3/13/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Law Funeral Home 4611 Park Heights Ave.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |



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Continued on page 2 of 2

MAR 18 1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 0 6 8 9 9

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CATHERINE B. DIXON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 22, 1981</b>                                    |  | 2b. HOUR<br><b>9:30</b> a.m.   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 7, 1905</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1611 Kingsway Road</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C.P.A.</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Accounting</b>                               |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1611 Kingsway Road</b>                                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John A. Bull</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lilly Koller</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 09 9681</b>   |   | 17 INFORMANT<br>ADDRESS<br><b>Miss Kathleen K. Dixon Same</b>                        |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma of pancreas</b><br><b>1579</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b> |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>January 1980</b> to <b>March 22, 1981</b> that (2) (we) last saw the deceased alive on <b>March 13, 1981</b> and that in (our) opinion death occurred on the date and hour and from the causes stated (observe how) (did/did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>D. Gail Wilson, M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>3/23/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gail Wilson, M.D.</b>  |  | 22e. ADDRESS<br><b>Good Samaritan Hospital, Balto., Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>3/23/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>                                |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>   |  |  |

4008 York Road, Balto., Md. 21212

Creation  
Henry W. Jenkins & Sons Co.  
Green Mount, Balto., Md.

MAR 23 1981

Dr. Carl Wilson, M.D.  
Good Samaritan Hospital, Balto., Md.

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No

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W. J. V. ; / 1981

John

Bull

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Kelly

Maryland

Baltimore

x

1011 Kingway Road

Baltimore

1011 Kingway Road

C.P.A.

Accounting

Maryland

USA

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E. Lincoln City

Female

Birth

Feb 7, 1981

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 4. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN DOCHERTY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 15, 1981</b>                             |  | 2b. HOUR<br><b>12:20 AM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 19 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Employed</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b>   |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Harford</b>  | 13c. CITY OR TOWN<br><b>Abingdon</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Docherty</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Keenan</b>                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>066 22 2447</b>  | 17. INFORMANT<br>ADDRESS<br><b>Rebecca Docherty 4228 Birch Ave. Abingdon, Md.</b>        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hepatic failure</b><br><b>5713</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic alcoholic liver disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>~ 48 hr</b><br><b>&gt; 8 months</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>esophageal variceal bleed</b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Feb 27</b> 19 <b>81</b> , to <b>march 15</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>march 15</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                        |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Nancy E Davidson</b> MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/15/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nancy E Davidson MD</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Mar. 18, 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Drexel Hill Pa.</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>                                      |  |  |
| ADDRESS<br><b>1905 York Rd. Baltimore, Md. 21212</b>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert Keenan</b>                                       |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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TO  
FROM  
DATE

Handwritten notes and stamps, including a large 'X' and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George E. Donaldson</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>20</b> YEAR <b>'81</b>               |  | 2b. HOUR<br><b>7:45 PM</b>                       |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>1</b> YEAR <b>1913</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b> |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>1607 Orlando Rd.</b>   |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>Donald</b> LAST <b>son</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lula</b> MIDDLE <b>Boley</b> LAST <b></b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>577-22-2429</b>  |   | 17. INFORMANT<br><b>MARGARET A. Donaldson</b> ADDRESS<br><b>Same</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Lung cancer with brain metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>6 months</b> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>November 20, 1980</b> to <b>March 20, 1981</b> , that (1) (we) lost saw the deceased alive on <b>March 20, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Paul Chang, MD</b>  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>3/20/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Chang, MD</b>   |   | 22e. ADDRESS<br><b>5601 Loch Raven Blvd., Baltimore</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SUFFICE)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>3/24/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |   | 24. FUNERAL DIRECTOR<br>NAME <b>EVANS FUNERAL CHAPEL</b> ADDRESS <b>8800 HARBOR RD</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 06902   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BRUCE John DONLEY</b>   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3-18</b> YEAR <b>81</b> |  |
| 3. SEX <b>male</b> 4. RACE <b>white</b> 5. DATE OF BIRTH <b>May 3, 1948</b> 6. AGE (IN YEARS) <b>32</b> YRS.   |  |  |  |  |  |  |  |  |  | 7b. HOUR <b>8:54</b> PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>3-18</b> YEAR <b>81</b>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |  |  |  |  |  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>South Baltimore General</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Surveyor= Md. Dept of Transport</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS <b>2410 Smith Ave.</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME <b>Leo W. Donley</b> 15. MOTHER'S MAIDEN NAME <b>Elsie M. Meehan</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT <b>Elsie M. Keltz R.F.D. 1 Littleton, N.H.</b>   |  |  |  |  |  |  |  |  |  | ADDRESS <b>03561</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Multiple injuries</b><br>IMMEDIATE CAUSE (a) <b>8/159</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>DOE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DOE TO, OR AS A CONSEQUENCE OF</b>   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>7:45PM 3-18-81</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>occupant of auto/fixed object impact</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>roadway</b> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>2500blk Hawkins Pt. Rd. Baltimore, Maryland</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell, M.D.</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>3-19-81</b>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>3/23/81</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Park</b> 23d. LOCATION (CITY OR TOWN) <b>Baltimore, Maryland</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgwy Balto 21225</b> 25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1981</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must) be notified and an autopsy requested.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 3106903   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| SUE WHITEFORD DONOVAN  |  | 3 24 81   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |
| Female   | White  | Nov. 29, 1906   | 74 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |
| Maryland   | USA  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>UNION MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bakery  |
| 13a. STATE<br>Maryland   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gustavis Clark   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Brown                        | 13e. STREET ADDRESS<br>725 E. 37th Street   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   | 16b. SOCIAL SECURITY NO.<br>212 38 1174  | 17. INFORMANT ADDRESS<br>Robert M. Donovan Jr., Balto., Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial Infarction</u><br>(c) <u>ASCVD</u>  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>None</u>  |  |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>81</u> , to <u>3/24</u> , 19 <u>84</u> , that <del>the</del> <u>two</u> lost saw the deceased alive on <u>3/24</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above <del>(the)</del> <u>(we)</u> <del>(did)</del> <u>(did not)</u> view the body after death. |  |   |  |
| 22b. SIGNATURE<br><u>C. J. Hudleston MD</u>  | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br><u>3/24/81</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>C. J. HUDLESTON</u>  | 22e. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>                                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b. DATE<br>3/27/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Co., Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |

800 York Road, Balto., Md. 21212

Henry V. Jenkins & Sons Co.,  
Parkwood

Balto., Co.,

Md.

MAR 2 1961

*Handwritten signature*

Burial

Maryland

Maryland

Female

No

212 38 1174

Robert W. Donovan Jr., Balto., Md.

Clark

Mary

Brown

Baltimore

125 E. 17th Street

Salaperson

Bakery

U.S.A.

Salaperson

White

Nov. 22, 1903

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANTHONY JOHN DORN</b>   |  |   | 20. DATE OF DEATH MONTH DAY YEAR<br><b>3-2-81</b>   |   | 2b. HOUR<br><b>10-15 PM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-12-09</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>  |   | # UNDER 1 YEAR<br>HOSPITAL DAYS HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>                              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO, MD.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CHAUFFEUR</b>   |  |
| 13a. STATE<br><b>MD.</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTO, MD.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3114 FOSTER AVE. 21224</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY J. DORN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY HAMMELMAN</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-07-0639</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>CHARLES H. DORN 1023 COLD SPRING RD. 130145 QUARTERS, 21224 MD</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRONCHO PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA LUNG METASTASE</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-25</b> , 19 <b>81</b> , to <b>3-2</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3-1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>REHMAN</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3-3-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. REHMAN</b>  |  | 22e. ADDRESS<br><b>2619-HAMMONDS FERRY RD BALTO.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>3-6-81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEM.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>7401 GERMAN HILL RD. BA, Co. MD</b>              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Deiler &amp; Son, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey Helmsky</b>  |  |



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4. *Results*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8106905   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (Type or Print)<br>(Tony) Anton M. Dorsey  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 20 81  |  | 2b. HOUR<br>1220 P.M.  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 27 37   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43<br>YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secour Hospital                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  |  |  | 13b. CITY OR TOWN<br>Baltimore  |  | 13c. STREET ADDRESS<br>127 Willowbend Drive  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Irvin I. Dorsey   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Curtis  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-32-9441   |  | 17. INFORMANT ADDRESS<br>Sandra V. Dorsey 1919 Hillenwood Road  |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Sudden death due to probable Cor. Ar.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arrhythmia; A.S.H.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Mitral valve regurgitation</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>None</u><br><u>? year</u><br><u>? year</u>                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) [this hospital] attended the deceased from <u>2-19</u> , 19 <u>81</u> , to <u>3-28</u> , 19 <u>81</u> , that (1) (we) lost sdw. the deceased alive on <u>3-28</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Thambers</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-21-81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ELIJAH SAUNDERS MD   |  | 22e. ADDRESS<br>PRUDENT HOSPITAL<br>2000 LIBERTY STS. 21216  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>3/26/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C. MARCH F/H INC. 1101 E. North Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia M. Brady</u>   |  |

(7)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |   |  |  |  | 8  | 1 | 0  | 6 | 9 | 0 | 6                          |  |
|--|--|--|--|---|--|---|--|--|--|--|---|--|---|---|---|----------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | REG. NO.   |   |  |   |   |   |                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Dorsey Cornelius</i>  |  |  |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 16 81</i>  |   |  |   |   |   | 2b. HOUR<br><i>8:25 PM</i> |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>Bl</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8 25 99</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS<br>HOURS MIN.  |   |  |   |   |   |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>CITY</i> MD.   |  |  |  |  |   |  |   |   |   |                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Univ</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>unemployed</i>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |   |   |   |                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):   |  |  |  |   |  |   |  |  |  |  |   |  |   |   |   |                            |  |
| 13a. STATE<br><i>MD</i>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Balto</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>11 W 20th St</i>   |  |  |   |  |   |   |   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>WOODCOCK</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>CHARLETT MINOR</i>  |  |   |  |  |  |  |   |  |   |   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>213 01 3101</i>  |  | 17. INFORMANT ADDRESS<br><i>Dorothy Johnson 4637 Coleherne Rd.</i>                              |  |  |  |  |   |  |   |   |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i><br><i>4360</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Bilateral CVA</i>                        |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 days</i><br><i>7 days</i>   |   |  |   |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>gastric outlet obstruction</i>  |  |  |  |   |  |   |  |  |  |  |   |  |   |   |   |                            |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |   |  |   |   |   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |   |  |   |   |   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |   |   |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/25/81</i> to <i>3/14/81</i> that (I) (we) last saw the deceased alive on <i>3/14/81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |   |  |   |   |   |                            |  |
| 22b. SIGNATURE<br><i>Margaret A Kaiser MD</i>  |  |  |  |   |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>3/16/81</i>                   |   |   |   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>KAISER</i>   |  |  |  |   |  |   |  |  |  | 22e. ADDRESS<br><i>Univ Hosp</i>   |   |  |   |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |  |  | 23b. DATE<br><i>3-21-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>King Mem. Pk.</i>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>                      |  |  |   |  |   |   |   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>CHAS. A. RICE FSPA 1300 Eutaw Place</i>   |  |  |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 19 1981</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Dorothy Johnson</i> |   |   |   |                            |  |

11

History of the City of New York



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-1

06907

REG. NO.

|  |  |   |  |   |  |   |   |  |   |  |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RICHARD DORSEY, JR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 1981</b>           |   | 2b. HOUR<br><b>9<sup>00</sup> P<sup>M</sup></b>          |   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 29, 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76 76</b> YRS.                                  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>76 76</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                     |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7 W. Melrose Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Rep.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Products</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7 W. Melrose Avenue</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Dorsey</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Ridgely</b>  |   |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212 09 9762</b>                         |   | 17. INFORMANT<br><b>Mrs. Grace Dorsey</b>                |   |   | ADDRESS<br><b>Same</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>METASTATIC CARCINOMA OF COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.        |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>5 YEARS</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>22 FEB</b> , 19 <b>73</b> , to <b>23 MARCH</b> , 19 <b>81</b> , that (I) <del>have</del> lost saw the deceased alive on <b>23 MARCH</b> , 19 <b>81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>will</del> (did) <del>not</del> view the body after death. |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Dixon Hills</b> M.D.   |  |   |  |   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>24 March 81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. J. Dixon Hills</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>3501 St. Paul St., Balto., Md.</b>                                 |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/26/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., Md. 21212</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Pitney Kelbrandy</b>  |   |  |

MEDICAL CERTIFICATION

2

9

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

2712



ICF B. 1001

Wife U. A. Baltimore City

7 W. Melrose Avenue Baltimore x 7 W. Melrose Avenue

Richard Dorsey Sarah Dorsey No 212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

Maryland Baltimore No

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

212-03-2782 Mrs. Grace Dorsey

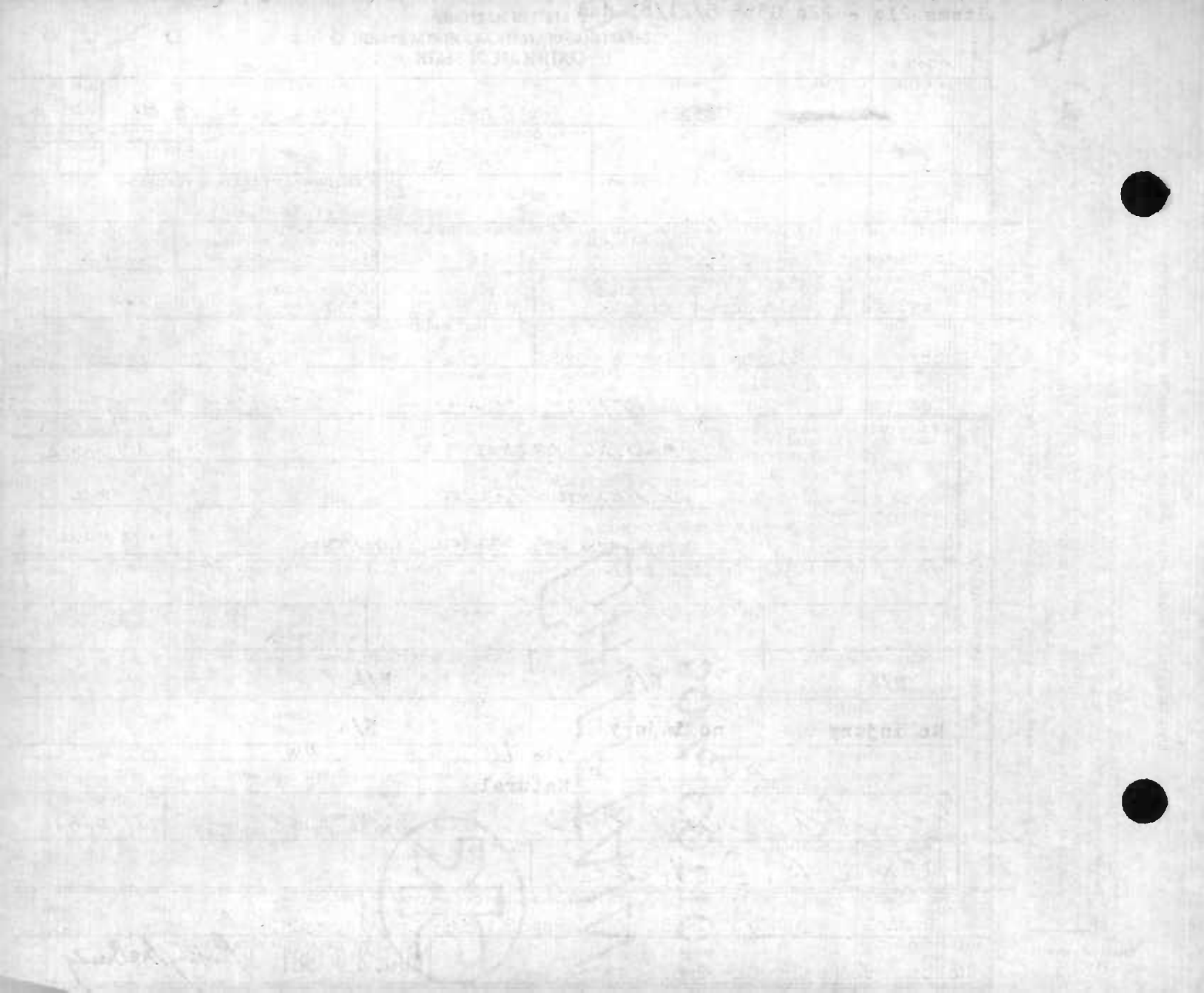
Dr. J. Dixon Hill, Jr., M.D. 6801 St. Paul St., Balto., Md. Burial 3/25/81 Fruit Ridge Pikeville, Henry W. Jenkins & Sons Co. 4805 York Road Balto., Md. 21215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| <div> <div>Items 21a - 22a G555 5/21/81 dad</div> <div>STATE OF MARYLAND</div> <div>DEPARTMENT OF HEALTH AND MENTAL HYGIENE</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>FOR</div> <div>1 - STATE REGISTRAR</div> </div> <div> <div>REG. NO.</div> <div>8 1 0 6 9 0 8</div> </div>                                 |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>George William Doyle Jr.  |  |  |  |  |  | 2a. DATE OF DEATH<br>3/18/81   |  | 2b. HOUR<br>12:50 A.M.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>1 12 1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mail Services       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Banking   |  |
| 13a. STATE<br>Maryland  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk   |  |
| 14. FATHER'S NAME<br>George William Doyle Sr.   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Anna E. Keating  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WWI  |  | 17. INFORMANT<br>Robert Doyle  |  | 17. ADDRESS<br>117 Dunkirk Rd. Balto. 21212  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASPIRATION OF GASTRIC CONTENTS</u>                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3/4 HOUR<br>1 HOUR<br>1 1/2 HOUR   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>N/A   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N/A  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>no injury <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>no injury   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N/A   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18 19 81 to 3/18 19 81, that (I) (we) last saw the deceased alive on 3/18 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>Natural</u> |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Emil A. Deliere MD  |  |  |  |  |  | 22c. DATE SIGNED<br>3/18/81  |  | 22d. ADDRESS   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Emil A. Deliere  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/20/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rosedale Balto. Md.                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Walter Brooks Bradley Inc. Balto., Md.  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy McBrady  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |   |  | 8 1 0 6 9 0 9  |  |                             |  |
|--|--|---|--|---|---|--|--|---|--|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |  |  |   |  | REG. NO.   |  |                             |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSE</b>   |  |   |  |   | MIDDLE<br><b>DRISCOLL</b>   |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-7-81</b>   |  | 2b. HOUR<br><b>11:05 AM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 26 1909</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.   |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |  |   |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                                 |  |  |  |                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2857 Lake Ave.</b> |   |  |  |  |                             |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   |  |  |   |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nicholas Peters</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth -</b>   |  |  |   |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-20-8943</b>  |   | 17. INFORMANT ADDRESS<br><b>John Driscoll (son) 5809 Arizona Ave.</b>                  |  |   |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AS CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hr</b><br><b>year</b>   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |   |  |  |   |  |  |  |                             |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |   |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |   |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/8/81</b> , 19 <b>81</b> , to <b>3/7</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/7</b> , 19 <b>81</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (If you did not view the body after death).                     |  |   |  |   |   |  |  |   |  |  |  |                             |  |
| 22b. SIGNATURE<br><b>Yoel Yokel MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br><b>3/7/81</b>   |  |  |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>YOEL YOKEL</b>   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |  |  |   |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/10/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                        |  |   |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Szymonek Funeral Home, Inc.</b>   |  |   |  | ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1981</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |                             |  |



UNITED STATES

DEPARTMENT OF COMMERCE

WASHINGTON, D.C.

NOT FOR



UNITED STATES DEPARTMENT OF COMMERCE

WASHINGTON, D.C.

MAR 11 1981



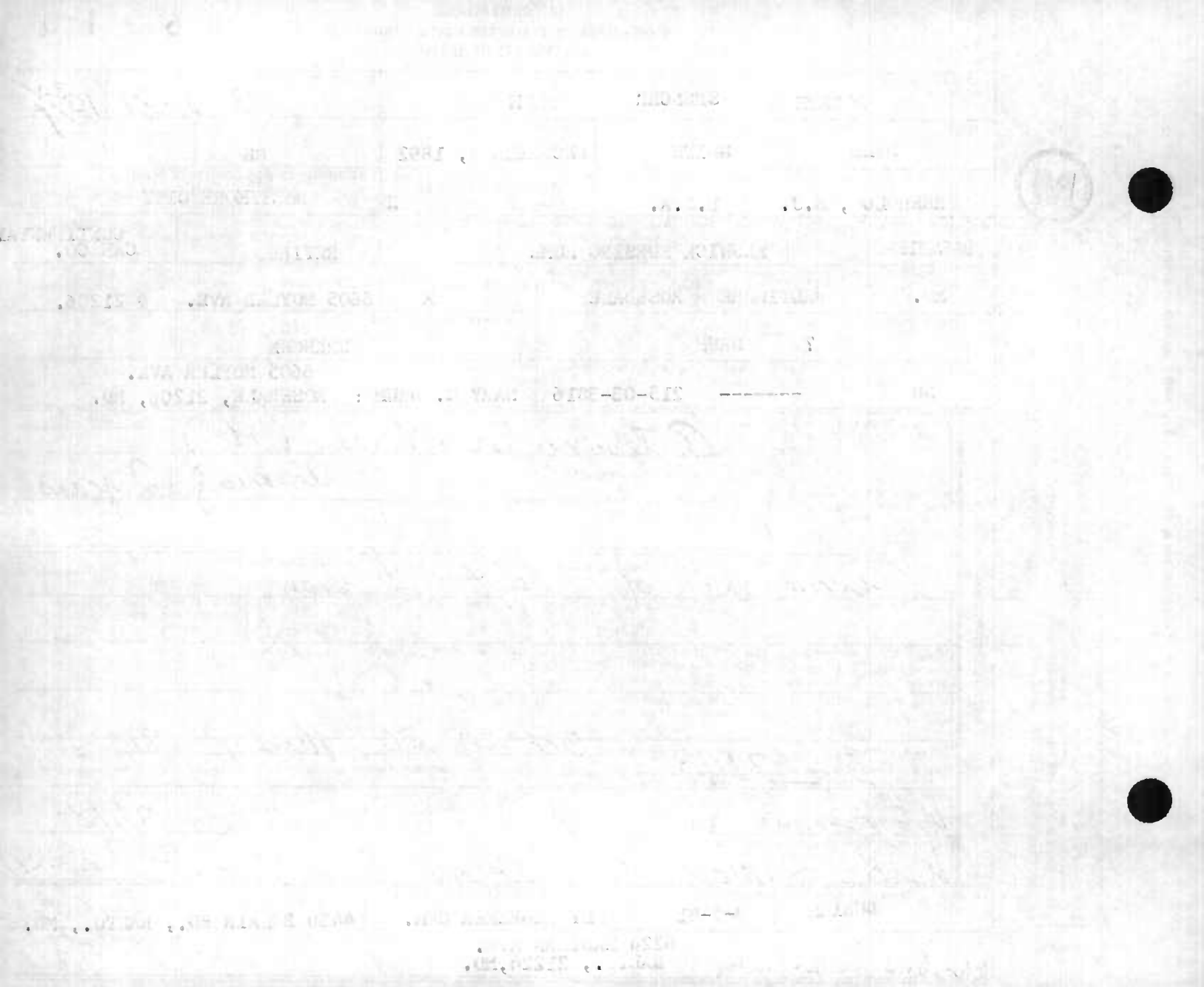
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  | 8   | 06910 |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|-------|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.  |       |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH SPENCER DRUM</b>   |  |   |  |   |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-1-81</b>   |       |  |  | 2b. HOUR<br><b>10<sup>30</sup> P.M.</b> |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>DECEMBER 4, 1892</b>  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88 YRS.</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>88</b>   |       | IF UNDER 1 HRS<br>HOURS MIN.<br><b>10<sup>30</sup></b> |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>FREEHOLD, N.J.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |   |       |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK NURSING HOME</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONTINENTAL CAN CO.</b>  |  |   |       |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |  |  |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>  |  | 13e. STREET ADDRESS<br><b>6605 MOYLER AVE. # 21206.</b>  |  |  |  |   |       |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>? DRUM</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |  |  |  |   |       |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-3816</b>  |  | 17. INFORMANT ADDRESS<br><b>MARY C. DRUM : 6605 MOYLER AVE. ROSEDALE, 21206, MD.</b>  |  |  |  |  |  |   |       |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis with uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>4039 } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years              |  |   |  |   |  |  |  |  |  |   |       |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Carcinoma of left kidney</b>  |  |   |  |   |  |  |  |  |  |   |       |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |       |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |       |  |  |   |  |
| 22a. I certify that (s) (this hospital) attended the deceased from <b>Oct 20, 1980</b> to <b>March 1, 1981</b> , that (we) last saw the deceased alive on <b>3/1/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |   |  |   |  |  |  |  |  |   |       |  |  |   |  |
| 22b. SIGNATURE<br><b>W.B. Daniels, Jr.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/1/81</b>  |  |   |       |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W.B. Daniels, Jr.</b>   |  |   |  | 22e. ADDRESS<br><b>Keswick, 700 W. 40th Bldg 21211</b>  |  |  |  |  |  |   |       |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-5-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>4430 BELAIR RD., BALTO., MD.</b>  |  |  |  |   |       |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles J. Gierke &amp; Son, Inc.</b>  |  |   |  | 46224 EASTERN AVE.<br>BALTO., 21224, MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |       |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one is available.

Drumgo, Annie

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |                                  |  |                                |  |                            | 8106911  |  |
|--|--|---|--|--|----------------------------------|--|--------------------------------|--|----------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |  |                                  |  |                                |  |                            | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |  | 2a. DATE OF DEATH                |  |                                |  |                            | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>Annie Drumgo  |  |   |  |  | MONTH DAY YEAR<br>3 24 81        |  |                                |  |                            | 12 15 A.M.   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |                                  | 6 AGE (IN YEARS LAST BIRTHDAY)   |                                | IF UNDER 1 YEAR  |                            | IF UNDER 24 HRS.   |  |
| female   |  | Black   |  | MONTH DAY YEAR<br>6 25 25  |                                  | 55 YRS.  |                                | MONTHS DAYS  |                            | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                                |  |                            |  |  |
| South Carolina   |  | U.S.A.  |  |  |                                  | Baltimore City MD.   |                                |  |                            |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                | 12b. KIND OF BUSINESS OR INDUSTRY                        |                            |  |  |
| Baltimore  |  | Provident Hospital  |  |  |                                  |  |                                |  |                            |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |                                  |  |                                |  |                            |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS?   |                                | 13e. STREET ADDRESS                                      |                            |  |  |
| Md.  |  |   |  | Balto.   |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                | 5406 Pembroke  |                            |  |  |
| 14 FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME         |  |                                |  |                            |  |  |
| FIRST MIDDLE LAST<br>Issac LEMON   |  |   |  |  | FIRST MIDDLE LAST<br>Ethel Smith |  |                                |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |  | 16b. SOCIAL SECURITY NO.         |  | 17 INFORMANT ADDRESS           |  |                            |  |  |
| no   |  |   |  |  |                                  |  | Ms. Bernice Voss 5406 Pembroke |  |                            |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.  |  |   |  |  |                                  |  |                                |  |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |  |
| IMMEDIATE CAUSE (a) <u>Caf Breast with metastases</u>  |  |   |  |  |                                  |  |                                |  |                            |  |  |
| 1749 DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                                  |  |                                |  |                            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |  |                                  |  |                                |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |                                  |  |                                |  |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |                                  |  |                                |  |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |                                  |  |                                |  |                            |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  |  |                                | 20a. AUTOPSY?  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |  |                                  |  |                                | YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                |  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> , 19 <u>81</u> , to <u>3-24</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-24</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                                  |  |                                |  |                            |  |  |
| 22b. SIGNATURE   |  |   |  |  |                                  | DEGREE   |                                |  | 22c. DATE SIGNED           |  |  |
|  |  |   |  |  |                                  |  |                                |  | 3/24/81                    |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  |                                  | 22e. ADDRESS   |                                |  |                            |  |  |
| Turgot Jeudy, M.D.   |  |   |  |  |                                  | 2600 Liberty Heights Avenue  |                                |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |                                  | 23c. NAME OF CEMETERY OR CREMATORY   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                            |  |  |
| Burial   |  |   |  | 3-28-81  |                                  | Mt. Auburn   |                                | Balto., Md.  |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  |  |                                  | 25a. DATE REC'D. BY REGISTRAR  |                                |  | 25b. REGISTRAR'S SIGNATURE |  |  |
| Leroy O. Dyett & Son   |  |   |  |  |                                  | 4600 Liberty Heights   |                                |  | MAR 24 1981                |  |  |



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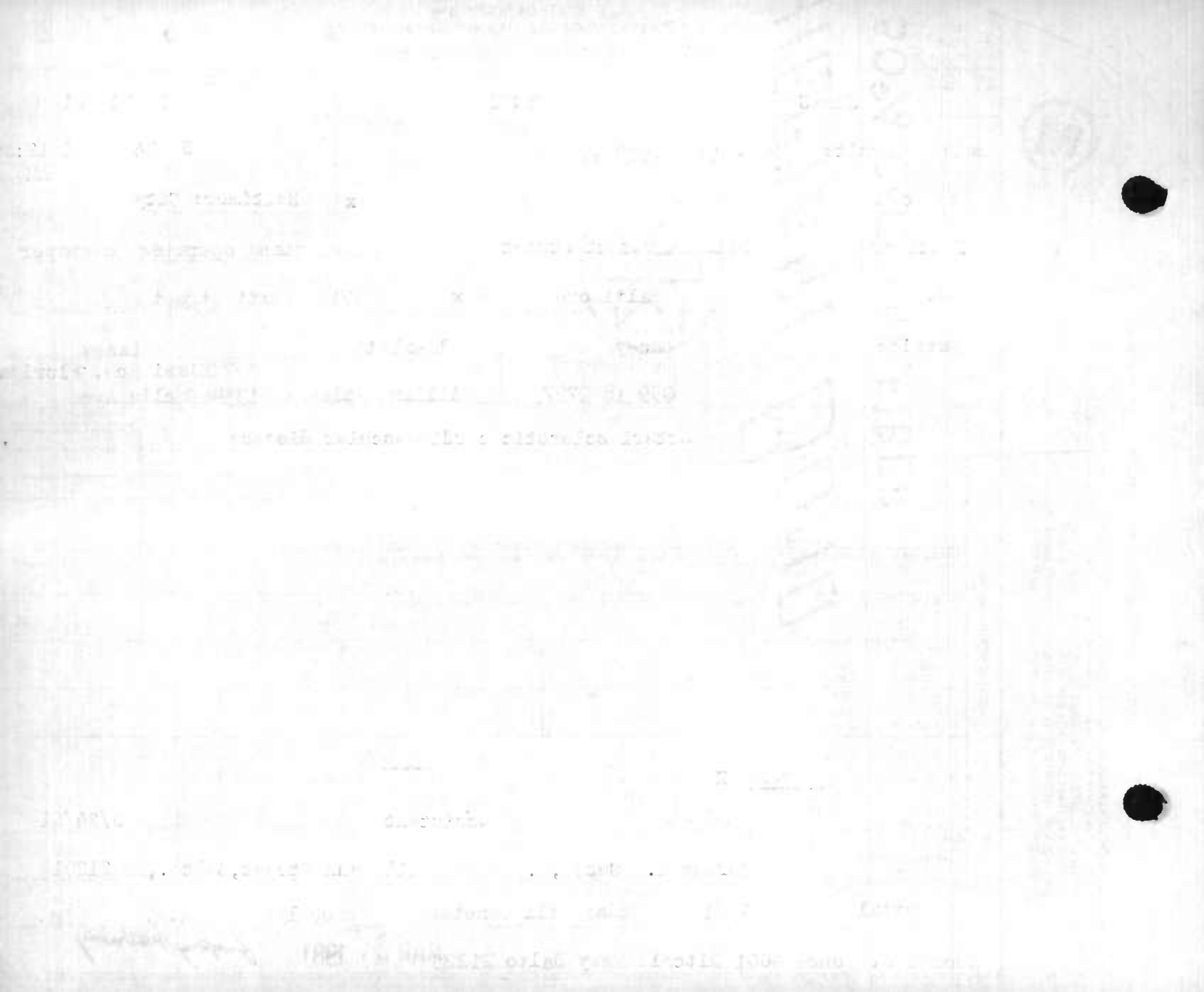
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO. 06912  |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES DUCEY</b>   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>24</b> YEAR <b>81</b> |  | 2b. HOUR <b>AM</b>   |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>- 13</b> YEAR <b>- 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.  |  | IF UNDER 24 HRS.<br>MONTHS <b>77</b> DAYS <b>77</b> HOURS <b>77</b> MIN. <b>77</b>                         |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>3</b> DAY <b>24</b> YEAR <b>81</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  | 10. BALTIMORE CITY OR COUNTY OF DEATH <b>AM</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3613 Everett Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>News stand operator</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>   |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 13e. STREET ADDRESS <b>3713 Evertt Street</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Patrick</b> MIDDLE <b>Ducey</b> LAST <b>Ducey</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Casey</b> LAST <b>Casey</b>   |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES) |  |   |  |
| 16a. SOCIAL SECURITY NO. <b>099 18 2727</b>  |  |   |  | 17. INFORMANT <b>Lillian Falanga</b>   |  |   |  | ADDRESS <b>Miami Bch, Florida</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b><br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                              |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>JR. Guard</b>  |  |   |  | TITLE (SPECIFY) <b>Assistant</b>   |  |   |  | DATE SIGNED <b>3/24/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |   |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/27/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Brooklyn</b> COUNTY <b>A.A.</b> STATE <b>Md.</b>                       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgwy Balto 21222</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>F. J. Kelly</b>   |  |  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 1 3

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUSSELL E. DULING</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>4</b> YEAR <b>81</b> |   |  | 2b. HOUR<br><b>3:00p</b> M   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>17</b> YEAR <b>94</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 South Athol Avenue</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Firefighter</b>                                     |  |
|   |  |   |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. STATE <b>Md</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13d. STREET ADDRESS <b>2 Overbrook Road</b>  |  |   |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>F.</b> LAST <b>Duling</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE <b>A.</b> LAST <b>Russell</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-144-3224</b>   |   | 17. INFORMANT <b>General German Aged Peoples Home</b> ADDRESS <b>22 S. Athol Avenue Baltimore, Md. 21229</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of prostate - metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 81</b> to <b>4 March 81</b> , that (I) (we) last saw the deceased alive on <b>March 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>William J. Bryson, M.D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>5 March 81</b>   |  | 22d. ADDRESS<br><b>5772 Westview Mall Baltimore, Md. 21228</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>3/6/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke Funeral Home of Catonsville</b><br>ADDRESS <b>1630 Edmondson Ave Catonsville, Md. 21228</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeffrey M. Brady</b>  |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|--|---|---|--|---|--|
| Item 6 8553 3/24/81 gj   |   | STATE OF MARYLAND   |  | 8 1 0 6 9 1 4   |  |
| 1. FOR<br>STATE<br>REGISTRAR   |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| JOHN W. DUNN   |   |   |  | 03 14 81  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Male   | White   | 8 8 39  |  | 40 41 YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Pennsylvania   | USA   |   |  | BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| Baltimore  | UNION MEMORIAL HOSPITAL   |   | Security Guard   |   |  |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS  |
| Maryland   |   | Baltimore   |  |   | 708 W. 33rd St.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |
| John W. Dunn Sr.   |   | Helen Gracila   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |
| Yes  |   | 1961-1964 213-38-7235   |  | Mrs. Helen Dunn 708 W. 33rd St. 21211   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF THE NECK<br>1734<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 1/4 YRS |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 11 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13/81, 1981, to 3/14/81, 1981, that (I) (we) last saw the deceased alive on 3/14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br>Serauld Ward   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>3/14/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SERALD WARD   |   | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>3/17/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Crest Lawn Gdns   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr. Funeral Home  |   | ADDRESS<br>3818 Roland Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Anthony A. Anthony   |   |   |  |   |  |



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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO. 8106915            |  |
|--|--|---|--|---|--|---|--|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>RACHEL H. DUNN   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 21 81  |  |  |  | 2b. HOUR PM<br>4:50 PM      |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAY 31, 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TEACHER                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>SCHOOL  |  |                             |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>116 UNIVERSITY PARKWAY  |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY C. HITCHINS   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CORA ANTHONY  |  |   |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>212-38-7345   |  | 17. INFORMANT ADDRESS<br>MISS CORA DUNN, BALTIMORE, MD.   |  |   |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u><br>4151<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Deep vein thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>7 days |  |   |  |   |  |   |  |  |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |  |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF DEATH HOUR A.M. MONTH DAY YEAR<br>4:50 P.M. Mar 21 1981  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>81</u> , to <u>3/21</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |                             |  |
| 22b. SIGNATURE<br>Julian Mayer Simmons MD  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br>3/21/81  |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JULIAN MAYER SIMMONS  |  |   |  | 22e. ADDRESS<br>Union Memorial Hosp Balto   |  |   |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>MAR. 24, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FROSTBURG MEMORIAL PK.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>FROSTBURG, ALLEGANY, MD.                             |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR NAME<br>DURST FUNERAL HOME, FROSTBURG, MD. 21532  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1981  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |                             |  |



RECEIVED MAY 24 1981 NATIONAL ARCHIVES COLLEGE PARK, MARYLAND

U.S. NATIONAL ARCHIVES COLLEGE PARK, MARYLAND

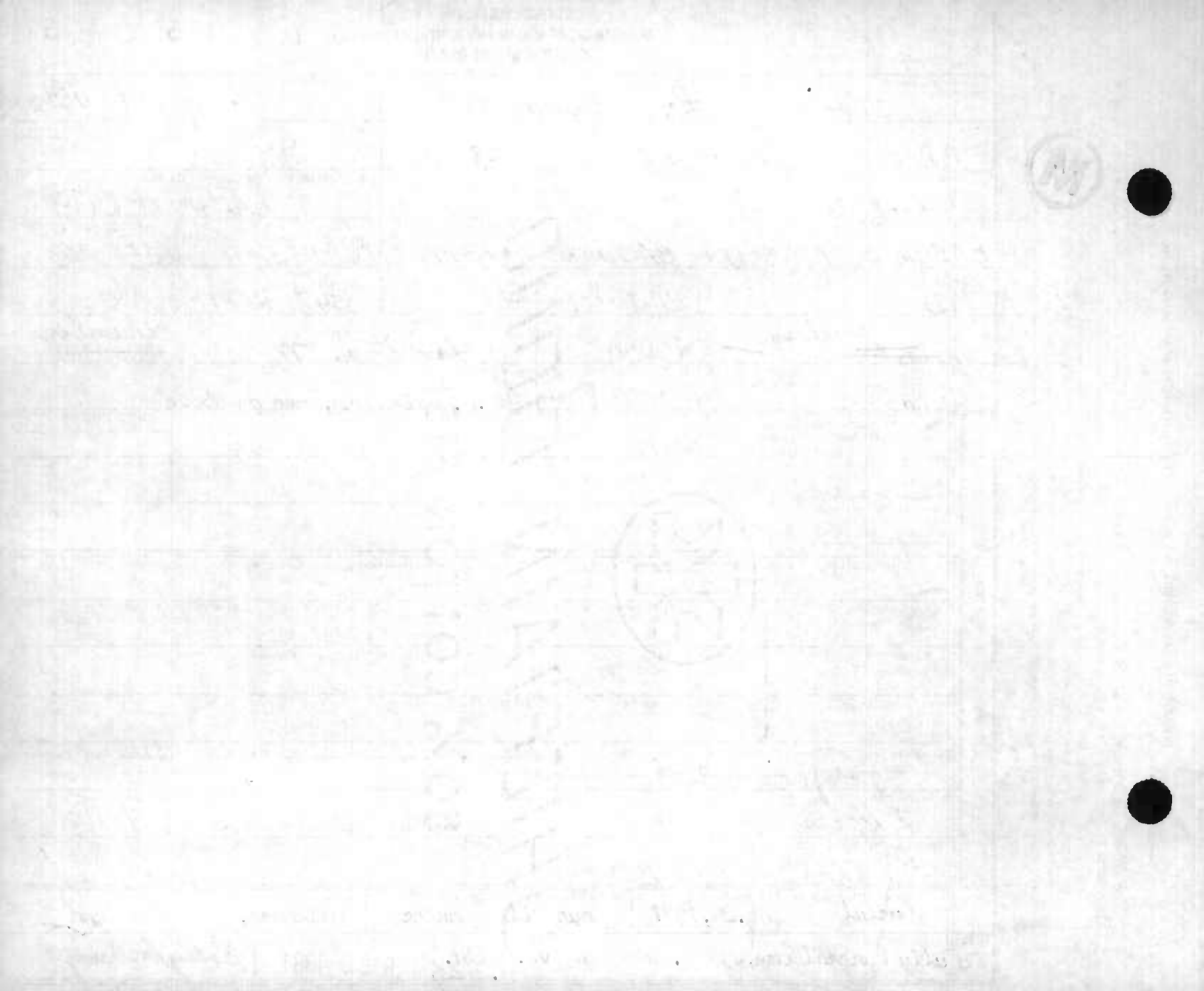
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 390-1111.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES L. DURM  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 21 81   |  |
| 2. SEX<br>MALE  |  | 2b. HOUR<br>954 A.M.  |  |
| 3. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 33 03   |  |
| 4. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE MD   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CHAUFFEUR   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>MEAT CO.   |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTIMORE  |  |
| 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES L. WILLIAMS DURM   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>MARIE EVA M. CHAMBERS HANKS  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-03-1191  |  |
| 17. INFORMANT ADDRESS<br>Mas. M. Marie Durm, Same as above  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 SUSPECTED MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12, 19 81, to 3/21, 19 81, that (I) (we) last saw the deceased alive on 3/20, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |   |  |
| 22b. SIGNATURE<br>Roy Cragway Jr. M.D.  |  | 22c. DATE SIGNED<br>3/21/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROY CRAGWAY JR. M.D.   |  | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 24, 1981  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>Baltimore, Maryland STATE  |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home, 237 E. Patapsco Ave. Balto.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Roy Cragway Jr.   |  |   |  |



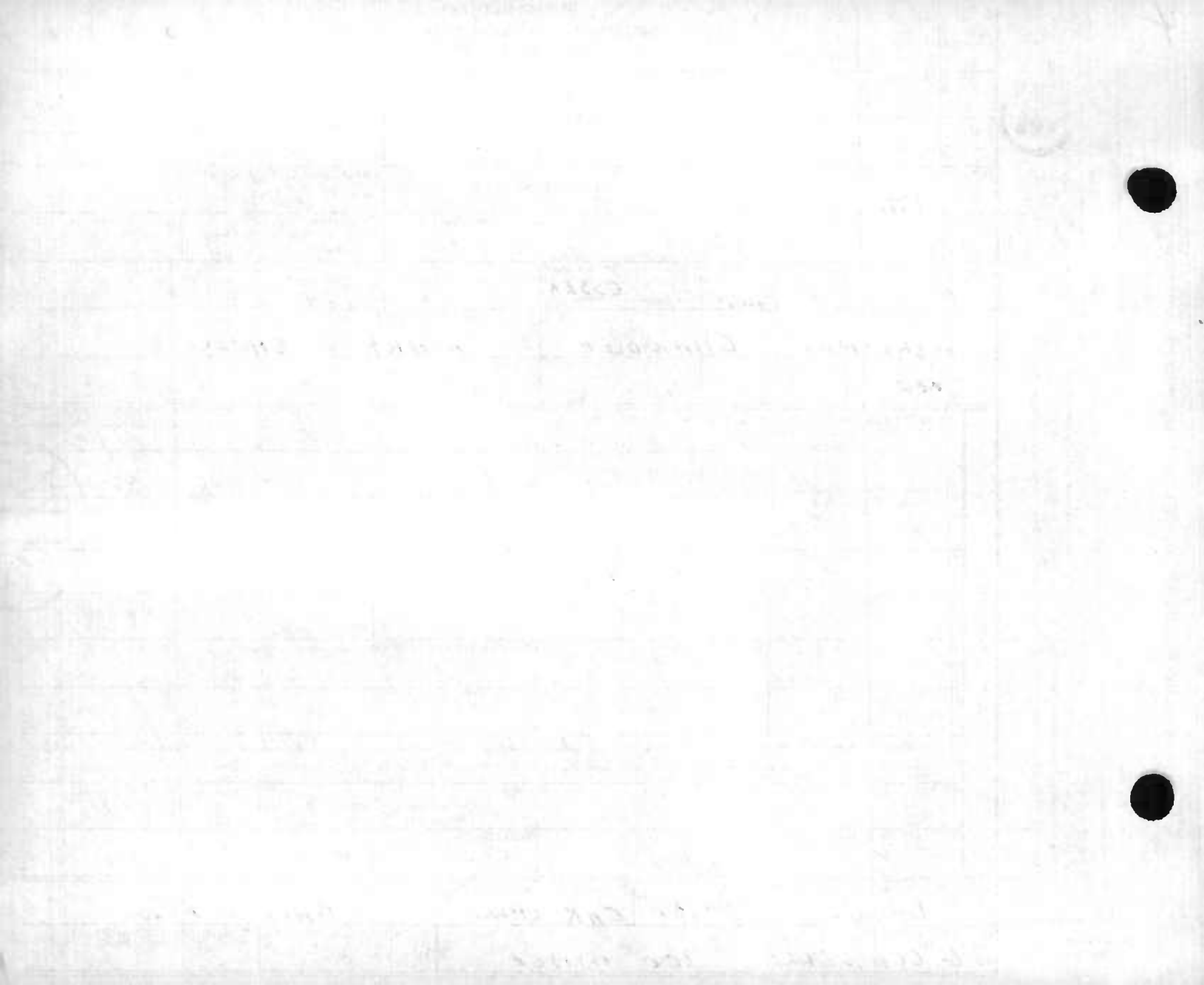
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |   |  |  |  | 8   | 1  | 0  | 6  | 9                             | 1 | 7                           |  |
|--|--|--|---|--|--|---|--|--|--|---|--|--|--|-------------------------------|---|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |   |  |  |  | REG. NO.  |  |  |  |                               |   |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary V Dye   |  |  |   |  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 11, 1981  |  |  |  | 2b. HOUR<br>10:45 AM          |   |                             |  |
| 3. SEX<br>female   |  |  | 4. RACE<br>Caucasian  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 13 20  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.                 |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |   |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |  |  |  |                               |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                               |   |                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Baltimore Baltimore  |  |  |   |  |  |   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>924 Barron Ave.   |                               |   |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM CHANDLER  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY SHULL           |   |  |  |  |   |  |  |  |                               |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>218-18-7647                            |   |  | 17. INFORMANT<br>Husband   |  |   |  |  | ADDRESS<br>Same  |                               |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) Oat cell lung cancer - metastatic<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>2 years                               |  |  |  |                               |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Asthmatic bronchitis.   |  |  |   |  |  |   |  |  |  |   |  |  |  |                               |   |                             |  |
| 19a. DATE OF OPERATION   |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                               |   |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |  |  |                               |   |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |                               |   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 7, 1981, to March 11, 1981, that (I) (we) lost saw the deceased alive on March 10, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  | 22b. SIGNATURE<br>Paul Chang, MD  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                               |   | 22c. DATE SIGNED<br>3/11/81 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul Chang, MD  |  |  |   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd., Balto., Md 21239            |   |  |  |  |   |  |  |  |                               |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |   |  | 23b. DATE<br>3/14/81   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN                                 |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD |  |  |                               |   |                             |  |
| 24. FUNERAL DIRECTOR NAME<br>J.G. CONNELLY   |  |  |   |  |  |   |  |  |  | ADDRESS<br>300 MACE   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981   |                               |   | 25b. REGISTRAR'S SIGNATURE  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

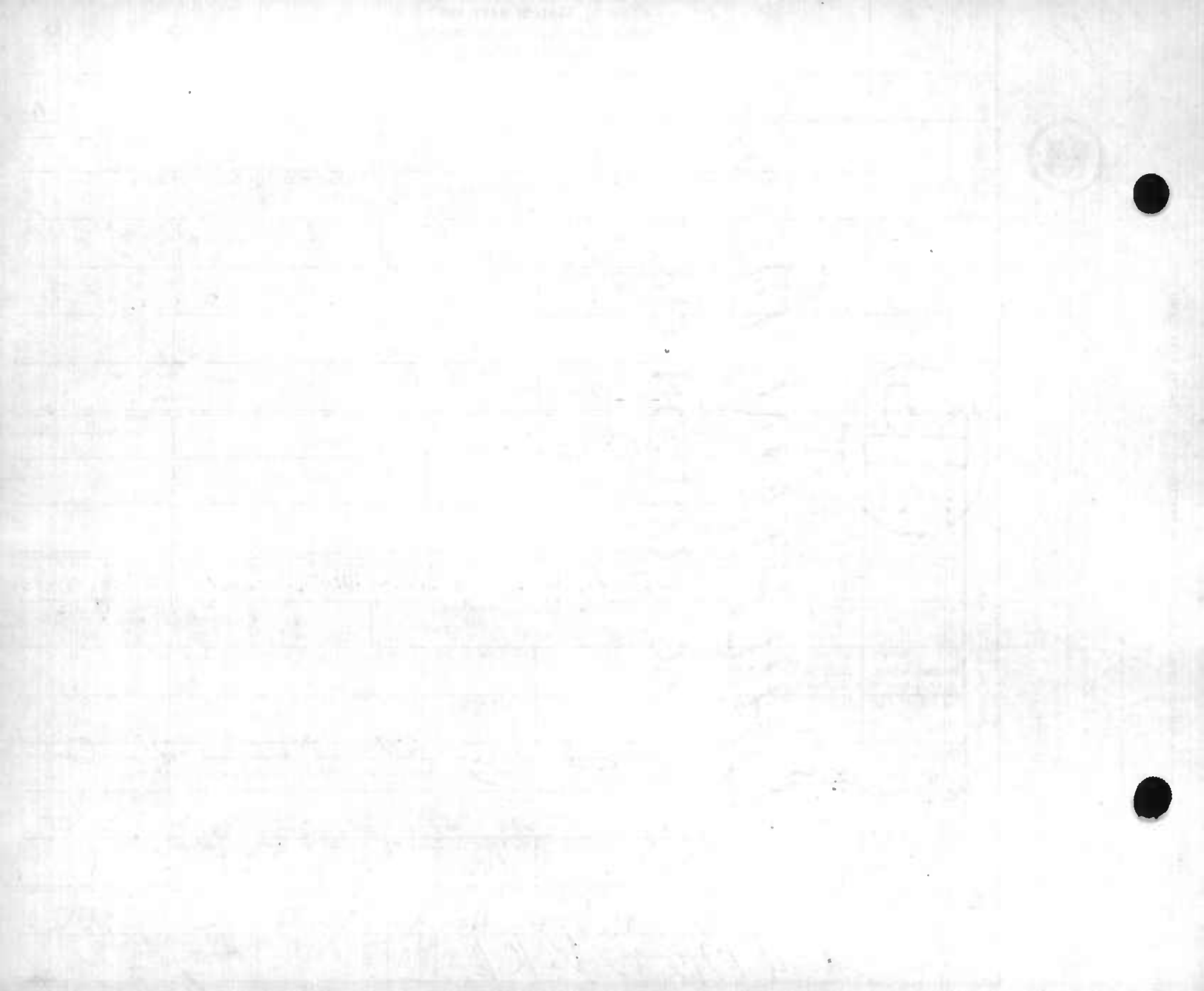
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |                                    |   |  | 8 1 0 6 9 1 8  |  |
|---|--|---|--|---|--|---|------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |   |                                    |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM DYSON</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>19</b> YEAR <b>81</b> |   | 2b. HOUR<br><b>9:30A</b> <b>AM</b> |   |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>31</b> YEAR <b>10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |                                    | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                    |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> <b>MD.</b>                                  |                                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1950 WEST MOSHER STREET</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |                                    | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    | 13e. STREET ADDRESS<br><b>1950 WEST MOSHER ST.</b>                                |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b></b> LAST <b>DYSON</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>CATHERINE</b> MIDDLE <b></b> LAST <b></b>  |  |   |                                    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>710-09-7225</b>   |  | 17. INFORMANT ADDRESS   |                                    |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |                                    |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>congestive heart failure, atherosclerotic coronary artery disease</b>   |  |   |  |   |  |   |                                    |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                    |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 24</b> 19 <b>81</b> to <b>Mar 1</b> 19 <b>81</b> , that (I) (we) last saw the deceased <b>alive</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)   |  |   |  |   |  |   |                                    |   |  |  |  |
| 22b. SIGNATURE<br><b>Christopher S. Stoner</b>  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |                                    | 22c. DATE SIGNED<br><b>3/20/81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Christopher S. Stoner</b>   |  |   |  | 22e. ADDRESS<br><b>Family Health Center<br/>University of Maryland Hospital</b>   |  |   |                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>3/23/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arboretum Men. Pk</b>  |  |   |                                    | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD.</b> STATE <b>MD.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Eric Canell</b> ADDRESS <b>1712 W. Park Ave</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>  |  |   |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |   |   | 8 1 0 6 9 1 9  |  |
|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |   |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE P EASTON</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3 26 81</b>  |  | 2b. HOUR<br><b>6:15 P.M.</b>                                     |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 7 19</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PURCHASING Agent BLACK, Decker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. STATE<br><b>MD.</b>   |   |   | 13b. CITY OR TOWN<br><b>WESTMINSTER</b>   | 13c. STREET ADDRESS<br><b>1802 Ridge Rd.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PAUL O EASTON</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA E MILLER</b>                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-07-4030</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>FRANCES EASTON S/A</b>                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPERKALEMIA</b>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>12 HR</b>  |
| 2050 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE RENAL FAILURE / CRF.</b>   |   |   |   |  | <b>24 HR</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHEMOTHERAPUTIC AGENTS</b>  |   |   |   |  | <b>6 YEARS</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>MYELOFIBROSIS / ACUTE MYELOGENOUS LEUKEMIA ?</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-21</b> , 19 <b>81</b> , to <b>3-26</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Thomas G. Higgins MD</b>  |   |   |   | 22c. DATE SIGNED<br><b>3-26-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS G. HIGGINS</b>  |   |   |   | 22e. ADDRESS<br><b>UNIVERSITY HOSPITAL</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>3/30/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTMINSTER</b>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WESTMINSTER CANAWA MD.</b>  |   | 23e. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>PRITTS Funeral Home WESTMINSTER</b>   |   |   |   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 20 working days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 685553 3/24/81 gj

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM EBERSOLE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> - DAY <b>1</b> - YEAR <b>81</b> |   |  | 2b. HOUR<br><b>2:45</b> AM   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> - DAY <b>5</b> - YEAR <b>09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> <del>72</del> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penn.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chief</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Kents Cafe</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>409 Delaware Ave</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Alvin</b> MIDDLE <b>D.</b> LAST <b>Ebersole</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lizzie</b> MIDDLE <b>Keefe</b>  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>549-01-9311</b>   |   | 17. INFORMANT ADDRESS<br><b>Mary K. Grant, Port Deposit, Maryland, 21904</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>2391</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PNEUMONIA</b><br>(c) <b>(R) LUNG MASS</b>             |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>3-1</b> 19 <b>81</b> to <b>3-1</b> 19 <b>81</b> that (2) (we) last saw the deceased alive on <b>3-1</b> 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (did not) view the body after death.) |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Patricia Snello</b> M.D.<br>DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><b>3/1/81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA SNELLO</b>  |  |  |   | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar. 3, 1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hopewell Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Port Deposit, Cecil, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lee A. Patterson &amp; Son, Perryville, Maryland</b><br><b>Lee A. Patterson &amp; Son Perryville, Md</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1981</b><br>25b. REGISTRAR'S SIGNATURE   |  |  |  |

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1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 25

## CERTIFICATE OF DEATH

REG. NO.

06921

1 - FOR  
STATE  
REGISTRAR1 DECEASED NAME  
(TYPE OR PRINT)Wilson Howard Eckert  
Wilson Eckert2a. DATE OF DEATH MONTH DAY YEAR 3 10 81  
2b. HOUR 10:30 PM

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

Jan. 25 1902

6 AGE (IN YEARS LAST BIRTHDAY)

79

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10 CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Baltimore City Hospital

12a. USUAL OCCUPATION

Hatter

12b. KIND OF BUSINESS OR INDUSTRY

Hat Mfg.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Maryland

13b CITY OR TOWN Baltimore

13c EASTPOINT

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET ADDRESS

7906 Park St. 21224

14 FATHER'S NAME

George Eckert

MIDDLE

LAST

15 MOTHER'S MAIDEN NAME

Mary Borchers

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

212 05 9534

17 INFORMANT

Violet Eckert, Wife

ADDRESS

Same

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

B. Ruching

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

3/10/81

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ELISARETH RUCHING

22e. ADDRESS

Balto City Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

3/14/81

23c. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

23d. LOCATION

CITY OR TOWN

Baltimore, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

Brudzinski Funeral Home

25a. DATE REC'D. BY REGISTRAR

MAR 13 1981

25b. REGISTRAR'S SIGNATURE

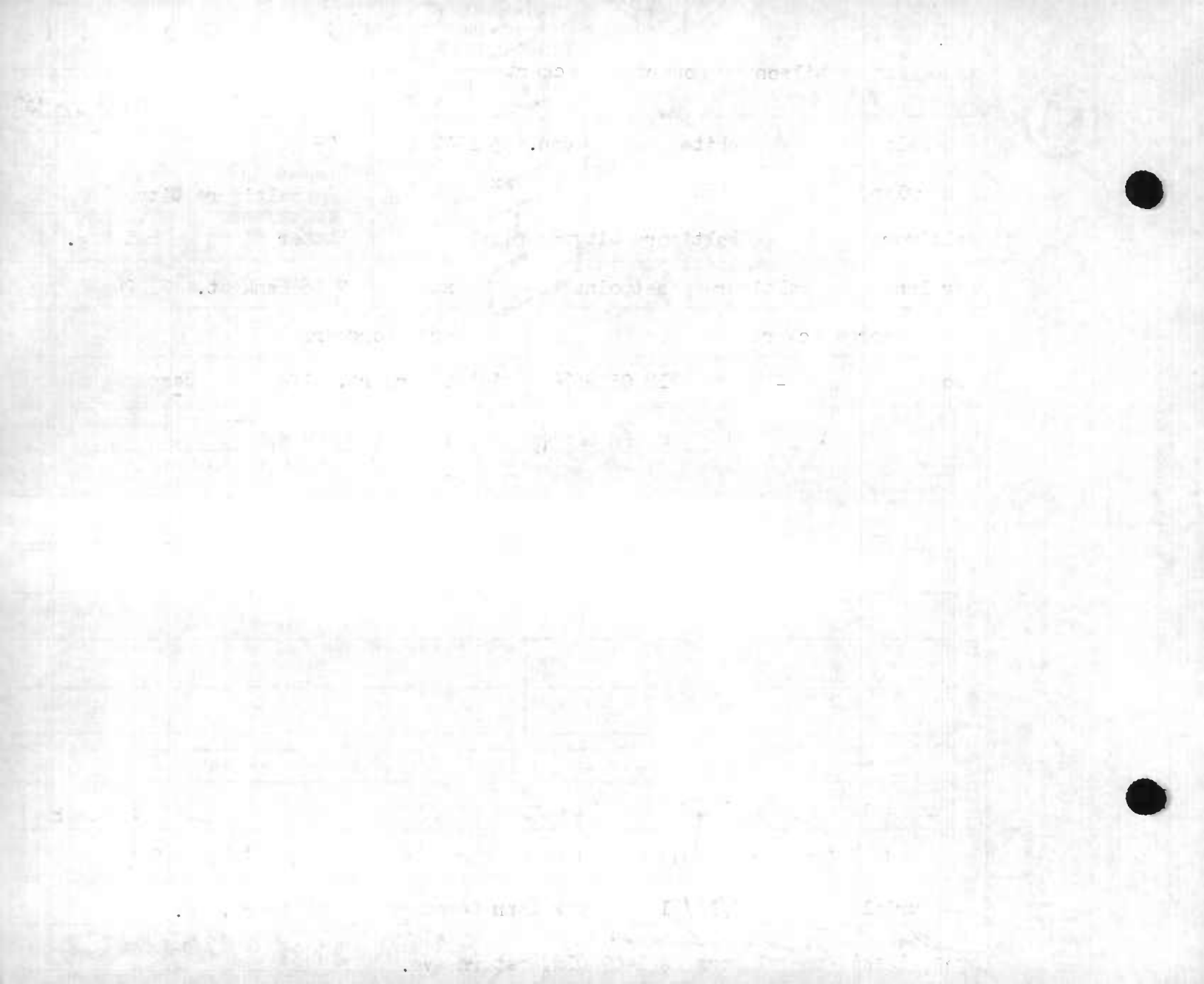
L. Ruching

PA 1407 Old Eastern Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

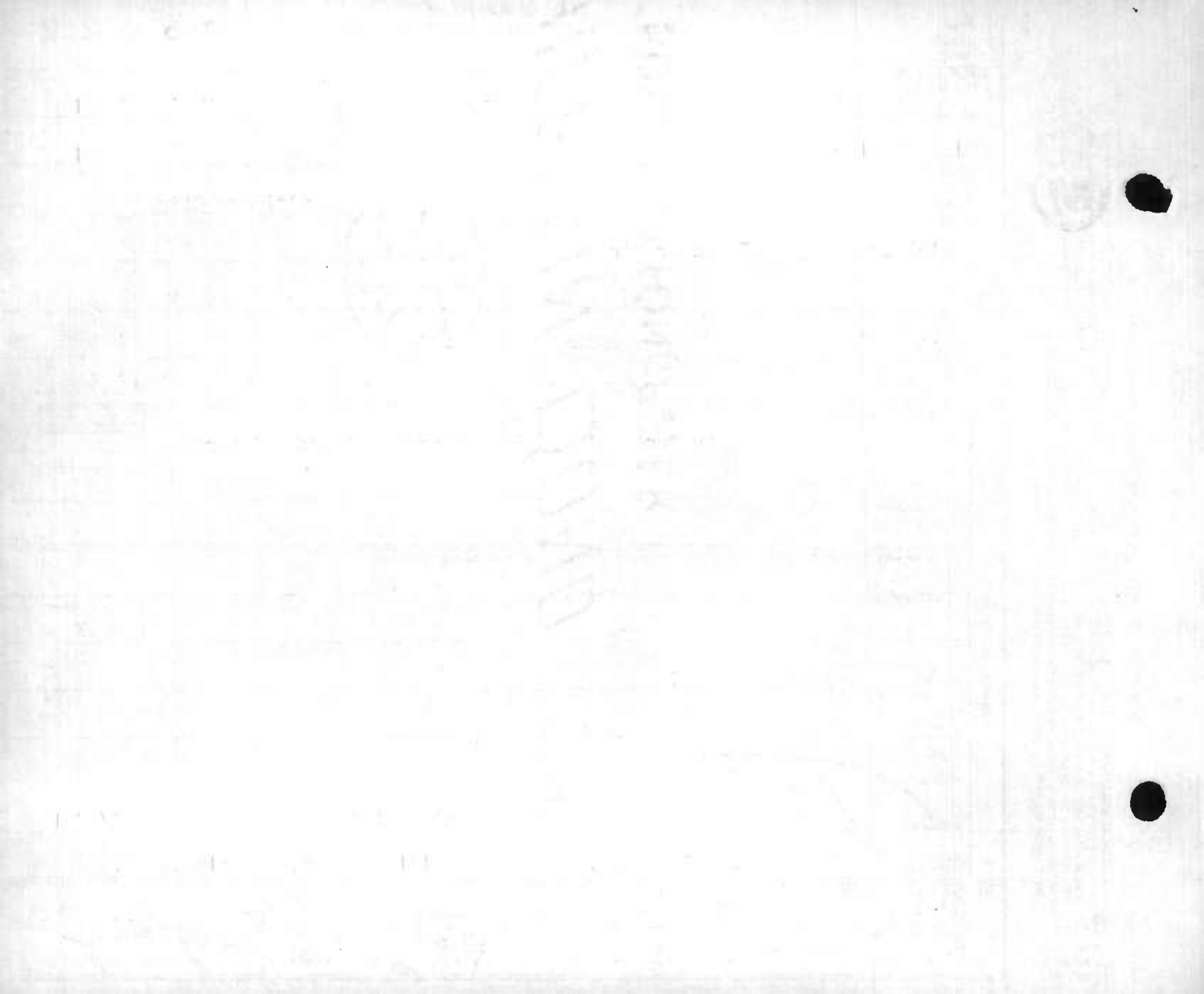
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06922

REG. NO.

|  |  |                                     |  |  |  |                   |  |   |  |  |  |   |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------------------|--|--|--|-------------------|--|---|--|--|--|---|--|--------------------------|--|---|--|---|--|---|--|--------------|--|---------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------|--|--|--|--|--|--|--|--|--|--------------|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. DECEASED NAME<br>(TYPE OR PRINT) |  | FIRST<br>Jesse   |  | MIDDLE<br>Edmonds |  | LAST<br>(Edmonds)   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED                   |  | MONTH<br>3  |  | DAY<br>3                 |  | YEAR<br>1981                                      |  | 2b. HOUR<br>M<br>3:52<br>P<br>M                 |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black                    |  | 5. DATE OF BIRTH<br>MONTH<br>11  |  | DAY<br>2          |  | YEAR<br>21  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>59                       |  | IF UNDER 1 YR.<br>MONTHS  |  | IF UNDER 24 HRS.<br>DAYS |  | 7c. DATE<br>PRONOUNCED<br>DEAD                    |  | MONTH<br>3                                      |  | DAY<br>5  |  | YEAR<br>1981 |  | 2d. HOUR<br>M<br>3:52<br>P<br>M |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Virginia   |  |                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>574 Baker Street |  |                   |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |                          |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY              |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                                     |  |  |  |                   |  |   |  |  |  |   |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Maryland   |  |                                     |  | 13b. COUNTY  |  |                   |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  | 13e. STREET ADDRESS<br>574 Baker Street           |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>William  |  |                                     |  |  |  |                   |  |   |  | MIDDLE<br>Jackson  |  |   |  |                          |  |   |  |   |  | LAST<br>Liddy   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Adams   |  |                                     |  |  |  |                   |  |   |  | MIDDLE<br>Adams  |  |   |  |                          |  |   |  |   |  | LAST<br>Adams   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                                     |  | (IF YES, GIVE WAR OR DATES)  |  |                   |  | 16b. SOCIAL SECURITY NO.<br>224-26-9236   |  |  |  | 17. INFORMANT<br>Linda Edmonds  |  |                          |  | ADDRESS<br>N.W. WASH. D.C.<br>4811 N. Capital St. |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured dissecting aneurysm of arch of aorta</u><br>4410<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                   |  |                                     |  |  |  |                   |  |   |  |  |  |   |  |                          |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                                     |  |  |  |                   |  |   |  |  |  |   |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                                     |  |  |  |                   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |   |  |                          |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |  |  |  |                   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  |   |  |                          |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                                     |  |  |  |                   |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  |   |  |                          |  |   |  |   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE                          |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |  |  |  |                   |  |   |  |  |  |   |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| ACTUAL<br>SIGNATURE<br><i>Thomas D. Smith</i>  |  |                                     |  |  |  |                   |  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                           |  |   |  |                          |  |   |  |   |  | DATE<br>SIGNED 3/6/81   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Thomas D. Smith, M.D.   |  |                                     |  |  |  |                   |  |   |  | ADDRESS<br>111 Penn St. Balto., MD.                            |  |   |  |                          |  |   |  |   |  |   |  |              |  |                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                     |  |  |  |                   |  |   |  | 23b. DATE<br>3/9/81  |  |   |  |                          |  |   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Vernon Hill Cemetery                          |  |              |  |                                 |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Halifax         |  |  |  |  |  |  |  |  |  | COUNTY<br>Co., |  |  |  |  |  |  |  |  |  | STATE<br>VA. |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH F/H INC.  |  |                                     |  |  |  |                   |  |   |  | ADDRESS<br>1101 E. North Ave.                                  |  |   |  |                          |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981   |  |              |  |                                 |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |  |  |  |  |  |  |  |                |  |  |  |  |  |  |  |  |  |              |  |  |  |  |  |  |  |  |  |

1403





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 9 2 3   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>Roland E. Eichelberger, Sr.   |  |  |  | MONTH DAY YEAR<br>3 23 84   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 7 24  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 yrs.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Military  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Army   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER EICHELBERGER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE L. TRACY   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1942-1963   |  | 17. INFORMANT<br>1919 Barry Road-Balto., MD.<br>Irene E. Eichelberger 21222   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF METASTATIC ADENOCARCINOMA COLON<br>(c) DUE TO, OR AS A CONSEQUENCE OF CL BLOODING 2° TO PORTAL HYPERTENSION |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/18, 19 81, to 3/23, 19 81, that (1) (we) lost saw the deceased alive on 3/23/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Paul R. Gustafson MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/23/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL R. GUSTAFSON M.D.  |  |  |  | 22e. ADDRESS<br>22 SO. GREENE ST BALTIMORE, MD.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| Burial   |  | 3/26/1981  |  | Holly Hill  |  | White Marsh Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |  |  | 25. DATE REG'D BY REGISTRAR<br>MAR 26 1981  |  |  |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |   |   |                                     | 8 1 0 6 9 2 4 |  |  |  |
|--|--|---|--|---|---|---|---|---|-------------------------------------|---------------|--|--|--|
| FOR STATE REGISTRAR  |  |   |  |   |   |   |   |   |                                     | REG. NO.      |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ruth H Eisinger</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 5, 1981</b>       |   |   |   | 2b. HOUR<br>AM PM<br><b>3:00 AM</b> |               |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 9m 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                                     |               |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |   |                                     |               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3212 Juneau Place</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                                     |               |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3212 Juneau Place</b>   |                                     |               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Hunter</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan ? ?</b> |   |   |   |                                     |               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-02-7831</b>  |  | 17. INFORMANT<br><b>Mr Leonard R Eisinger</b>   |   |   | ADDRESS<br><b>Same</b>                                |   |                                     |               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>A.S.C.V.D. HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>FEW HRS.</b><br><b>7 YRS.</b> |  |   |  |   |   |   |   |   |                                     |               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>CEREBRO-VASCULAR ACCIDENT.</b>  |  |   |  |   |   |   |   |   |                                     |               |  |  |  |
| 19a. DATE OF OPERATION<br><b>No</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>No</b>   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>No</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>No</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>No</b>  |   |   |   |   |                                     |               |  |  |  |
| 21d. INJURY OCCURRED <b>No</b><br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |   |   |   |   |                                     |               |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/27 1978</b> , to <b>3/4 1981</b> , that (1) (we) lost saw the deceased alive on <b>2/26 1981</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |   |   |                                     |               |  |  |  |
| 22b. SIGNATURE<br><b>P. C. Kahle M.D.</b>  |  |   |  |   | DEGREE<br><b>M.D.</b>   |   |   | 22c. DATE SIGNED<br><b>3/5/81</b>   |                                     |               |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Pochna C Kahle M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>8508 Loch Raven Blvd Baltimore, Md</b>         |   |   |   |                                     |               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>3/9/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |   |   |                                     |               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   |  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1981</b>                 |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBriney</b> |   |                                     |               |  |  |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |   |  |   |  | 8  | 1   | 0  | 6                           | 9 | 2 | 5 |
|---|--|--|---|---|--|---|--|---|--|--|---|--|-----------------------------|---|---|---|
| 1. FOR STATE REGISTRAR  |  |  |   |   |  |   |  |   |  | REG. NO.   |   |  |                             |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>THOMAS E. ELLIOTT</b>  |  |  |   |   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 31 81</b>   |   | 2b. HOUR<br><b>1:30 A.M.</b>                     |                             |   |   |   |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>   |   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 1, 1910</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>YRS.</b>                    |  | IF UNDER 24 HRS. HOURS MIN. |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD                                 |  |   |  |                             |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick Nursing Home</b> |   |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Gen. Superintendent</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Harry I. Campbell</b> |  |                             |   |   |   |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>11100 Pool Rd. 21030</b>            |  |                             |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>J. Leroy Elliott</b>  |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth M. Almony</b>  |  |   |  |  |   |  |                             |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-4578</b>  |   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Marie Belt, 11102 Pool Rd. Md. 21030</b>   |  |   |  |  |   |  |                             |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular occlusions, multiple</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Arteriosclerotic vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 years</b><br><b>5 years</b> |  |  |   |   |  |   |  |   |  |  |   |  |                             |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |   |  |   |  |  |   |  |                             |   |   |   |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |   |  |                             |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |   |  |                             |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |                             |   |   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Feb 27 19 79</b> , to <b>March 31 19 81</b> , that (1) (we) last saw the deceased alive on <b>March 31 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (a) (did) (d) (not) view the body after death.  |  |  |   |   |  |   |  |   |  |  |   |  |                             |   |   |   |
| 22b. SIGNATURE <b>W. B. Daniels, Jr.</b> DEGREE   |  |  |   |   |  |   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/31/81</b>               |                             |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. B. Daniels, Jr.</b>  |  |  |   |   |  |   |  |   |  | 22e. ADDRESS<br><b>Keswick, 700 W 40th St. Baltimore 21211</b>   |   |  |                             |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   | 23b. DATE<br><b>4-4-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Cockeysville Maryland</b>  |   |  |                             |   |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Iowson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |   |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |                             |   |   |   |

BP



Back to our family home, Inc. 2000, 2000, APR 2 1970  
P.O. Box 1000, Valley County, Idaho 83455



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| FOR<br>1 - STATE<br>REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 6 9 2 5<br>REG. NO.                           |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>[TYPE OR PRINT] FIRST MIDDLE LAST<br><b>JOHN M. ELLIS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03-19-81</b>  |  |  |  | 2b. HOUR<br><b>8:20 P.M.</b>                        |  |  |  |
| 3. SEX<br><b>male</b>   |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>07 15 01</b>   |  | 6. AGE [IN YEARS LAST BIRTHDAY]<br><b>79</b>   |  | 7 UNDER 1 YEAR MONTHS DAYS                          |  | 8 UNDER 1 YEAR HRS. MINS.                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hosp.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY                    |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Farmville, Va.</b>  |  |   |  | 13b CITY OR TOWN<br><b>Baltimore</b>   |  | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  | 13d STREET ADDRESS<br><b>4115 Chatman Rd. 21207</b> |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizabeth Reed</b>  |  |  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>1 unknown</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>213-01-4219</b>   |  | 17. INFORMANT ADDRESS<br><b>Frank J. Ellis, 4115 Chatman Rd. 21207</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause, or line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1850</b> IMMEDIATE CAUSE (a) <b>Septic Shock 2° UTI</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Stroke</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>3 Carcinoma of Prostate gland with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>D. mellitus; Correlative Heart failure, CRF</b> |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9/81</b> to <b>3/19/81</b> , that (I) (we) last saw the deceased alive on <b>3/19/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Beltran MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>3/20/81</b>   |  |  |  | 22d. ADDRESS<br><b>Bon Secours Hospital</b>         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY <b>Burial</b>  |  | 23b. DATE<br><b>3/25/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Baltimore, Maryland</b>  |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home</b>  |  |   |  | 24b. ADDRESS<br><b>4611 Park Heights Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b> |  | 25b. SIGNATURE<br><b>[Signature]</b>         |  |

RECEIVED  
MAY 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

Memphis, Tenn. x

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1a

For Special Agent in Charge, FBI, Memphis, Tenn.

Special

3/15/64

3/15/64 Cedar Hill Cemetery, Baltimore, Maryland

3/15/64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any.

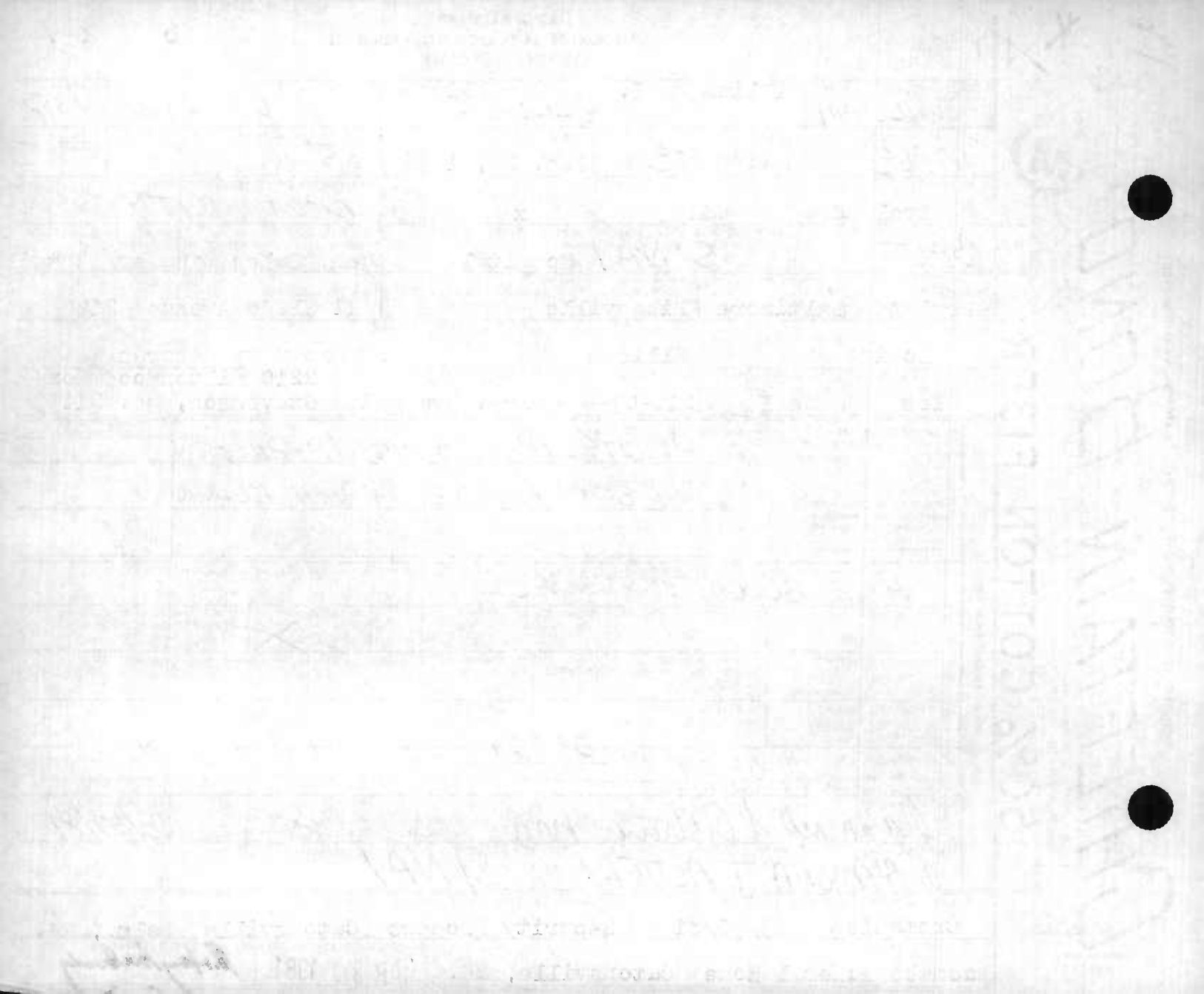
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM</b>   |  | FIRST <b>William</b> MIDDLE <b>I.</b> LAST <b>ELLISON</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03 29 81</b>   |  | 2b. HOUR<br><b>4:35P</b>  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 28, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>85 85 YRS.</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALT</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Gen. Sales Manager/ Retail</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b>   |  |  |  | 13c. CITY OR TOWN<br><b>Pikesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST <b>Louis</b> MIDDLE <b>Ellison</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unknown</b> MIDDLE <b>to Records</b> LAST  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>  |  | 17. INFORMANT<br><b>2210 Wilton Wood Road</b>   |  | 17. ADDRESS<br><b>Mrs. Hya Heine Stevenson, Md. 21153</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>LEFT BUNDLE BRANCH BLOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HIGH BLOOD PRESSURE</b>                                       |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/29</b> , 19 <b>81</b> , to <b>03/29</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>03/29</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 23a. SIGNATURE<br><b>Raymond J. Actier M.D.</b>   |  |  |  | 23b. DEGREE<br><b>M.D.</b>  |  | 23c. DATE SIGNED<br><b>03/29/81</b>   |   |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND J. ACTIER</b>   |  |  |  | 23e. ADDRESS<br><b>SINAI</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/30/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balt., Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MacNabb Funeral Home</b>   |  |  |  | ADDRESS<br><b>Catonsville, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>   |   |

25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |                            |  |
|---|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ARTHUR RAY EMMERT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 19 1981</b> |  | 2b. HOUR<br><b>10:45PM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 31 34</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                            |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD   |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Church Home Hospital</b>   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance Man</b>           |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                            |   |  |                            |  |
| 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                            |  |
| 13e. STREET ADDRESS<br><b>2538 E. Baltimore Street</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Emmert</b>  |   |  |                            |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Jane Bailey</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   |  |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>232-52-8689</b>  |  | 16c. INFORMANT<br>NAME ADDRESS<br><b>William D. Hicks, 2924 Erdman Avenue<br/>Baltimore, Md.</b>   |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ARTERY DISEASE</b>   |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ( )  |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |  |                            |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                            |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-8</b> 19 <b>81</b> , to <b>3-19</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3-19</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><i>V. Balakrivhnan</i>  |  |  |   | 22c. DATE SIGNED<br><b>3-19-81</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. BALAKRIVHNNAN, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 NORTH BROADWAY, BALTIMORE, MARYLAND 21231</b> |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-23-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Cemetery</b>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nicholas T. Matthews, 3021 Eastern Ave., Balto.</b>   |   |  |                            |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Bailey</i>  |   |  |                            |  |

184 8 JAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 6 9 2 9  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ELISABETH M. EMORY   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>MARCH 22, 1981  |  | 2b HOUR<br>M   |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>JULY 9, 1892   |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.<br>88  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6122 THE ALAMEDA |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>HOTEL  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD.   |  |   |  | 13b COUNTY<br>BALTIMORE  |  | 13c CITY OR TOWN<br>BALTIMORE  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JOHN T. MURPHY  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ALICE KENLY   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-01-6157A   |  | 17 INFORMANT ADDRESS<br>ARTHUR J. EMORY JR. 6122 THE ALAMEDA 21239   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>_____ years |  |   |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b SIGNATURE<br><u>Miguel Karacouschansky</u>  |  |   |  | DEGREE<br>M.D.   |  | 22c DATE SIGNED<br>3-23-81   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIGUEL-KARACOUSCHANSKY  |  |   |  | 22e ADDRESS<br>300 E. 3rd St 21218   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b DATE<br>MAR. 24, 1981   |  | 23c NAME OF CEMETERY OR CREMATORY<br>ST. STEPHENS CEM.   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BRADSHAW MD.  |  |
| 24 FUNERAL DIRECTOR NAME<br>MITCHELL-WIEDEFELD HOME   |  |   |  | ADDRESS<br>6500 YORK RD. 21212   |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |  |
|   |  |   |  | 25b REGISTRAR'S SIGNATURE<br><u>Miguel Karacouschansky</u>   |  |  |  |



Handwritten text, possibly a signature or date, in the middle of the page.

Handwritten text at the bottom of the page, including what appears to be a signature.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |  |  |  |  |  | REG. NO. 06930  |  |
|--|-------------------------|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Keith R. England</b>  |                         |  |  |   |  |  |  |  |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/><br>MONTH DAY YEAR<br><b>3 14 81</b> |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 24 56</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>24 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3 14 81</b>                             |  | 2d. HOUR<br>AM PM<br><b>12:50 AM</b>   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                            |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Funeral Director</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Funeral</b>  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. CITY OR TOWN<br><b>A.A. Linthicum</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>5700 E. Hammonds Ferry Road</b>                                |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert E. England</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Smith</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-70-6671</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Robert E. England 5700 E. Hammonds Ferry</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Head Injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                         |  |  |   |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10:40 PM 3/13 81</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>passenger in auto/fixed object collision</b> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>roadway</b>   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Marriottsville Rd &amp; Liberty Rd, Balto Co, MD</b>                     |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>H.R. Guard</b>  |                         |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | DATE SIGNED<br><b>3/15/81</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         |  |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |  |  | 23b. DATE<br><b>03-17-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |                         |  |  | ADDRESS<br><b>21229</b>   |  | 25a. MAR 16 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |



MAR 1 8 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |                        |   |  |   |   |  |  |   |  |
|--|--|---|------------------------|---|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |                        |   | 8 1 0 6 9 3 1  |   |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |                        |   | 2a. DATE OF DEATH  |   |   |  |  |   |  |
| FIRST MIDDLE LAST<br>William Irvin Enos  |  |   |                        |   | MONTH DAY YEAR<br>3 15 81  |   |   |  |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 22 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                    |   | 2b. HOUR<br>12 <sup>35</sup> PM  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                        |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO, MD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |                        |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chauffeur |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Airport   |  |   |  |
| 13a. STATE<br>Md.  |  |   |                        |   | 13b. COUNTY<br>Baltimore   |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>333 S. Stricker St. 21223 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Enos   |  |   |                        |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Bosley   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes  |  |   |                        |   | 16b. SOCIAL SECURITY NO.<br>215-09-8009  |   | 17. INFORMANT ADDRESS<br>Mrs. Mildred E. Enos (as above)  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia involving R lung</u><br>4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>months<br>years |  |   |                        |   |  |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic Renal Failure (atherosclerotic)</u>   |  |   |                        |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |                        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                        |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |                        |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 3</u> , 19 <u>81</u> , to <u>March 15</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>MARCH 14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                |  |   |                        |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>R. Cranley</u> MD   |  |   |                        |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><u>3/16/81</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. CRANLEY MD</u>  |  |   |                        |   | 22e. ADDRESS<br>900 CATON AVE. BALTO. MD. 21229  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/18/1981 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 3512 Frederick Ave.   |  |   |                        |   | 25a. DATE REC'D. BY REGISTRAR<br>21229<br>MAR 19 1981  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |

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FIG. 4.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |   |  |  |   |  |
|--|--|---|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |  | REG. NO.  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ROLAND E ESTES</b>   |  |   |   |  | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>30</b> YEAR <b>1981</b> 2b. HOUR <b>9<sup>10</sup> A.M.</b> |  |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>B</b>  |   | 5. DATE OF BIRTH MONTH <b>3</b> DAY <b>8</b> YEAR <b>1909</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.                                 |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ba Hg, Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                 |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE <b>Md</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Balto</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  | 13e. STREET ADDRESS <b>3325 Piedmont Ave</b>  |  |  |   |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Estes</b> LAST <b>Agnes</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b> MIDDLE <b>Grass</b> LAST <b>Grass</b>                   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |   |   |  | 16b. SOCIAL SECURITY NO. <b>212-14-239</b>  |  | 17. INFORMANT ADDRESS <b>Thelma Estes 3325 Piedmont Ave</b>              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> 4360  |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BILATERAL CEREBROVASCULAR ACCIDENT</b> 2 months  |  |   |   |  |   |  |  |   |  |
| (c) <b>ARTERIOSCLEROSIS</b> 20 years   |  |   |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DEBRUITI ULCERS</b>  |  |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 24 1981</b> to <b>Mar 30 1981</b> , that (1) (we) last saw the deceased alive on <b>Mar 30 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |  |   |  |
| 22b. SIGNATURE <b>William C. March</b> DEGREE <b>MD</b>  |  |   |   |  | 22c. DATE SIGNED <b>3-30-81</b>   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. NIKANAKIS</b>  |  |   |   |  | 22e. ADDRESS <b>PROVIDENT HOSP.</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   | 23b. DATE <b>4/3/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>  |  | 23d. LOCATION CITY OR TOWN <b>Balto</b> COUNTY <b>Co</b> STATE <b>Md</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>William C. March F/H 1101 E. North Ave</b> ADDRESS <b>1101 E. North Ave</b>   |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 31 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>                  |   |  |



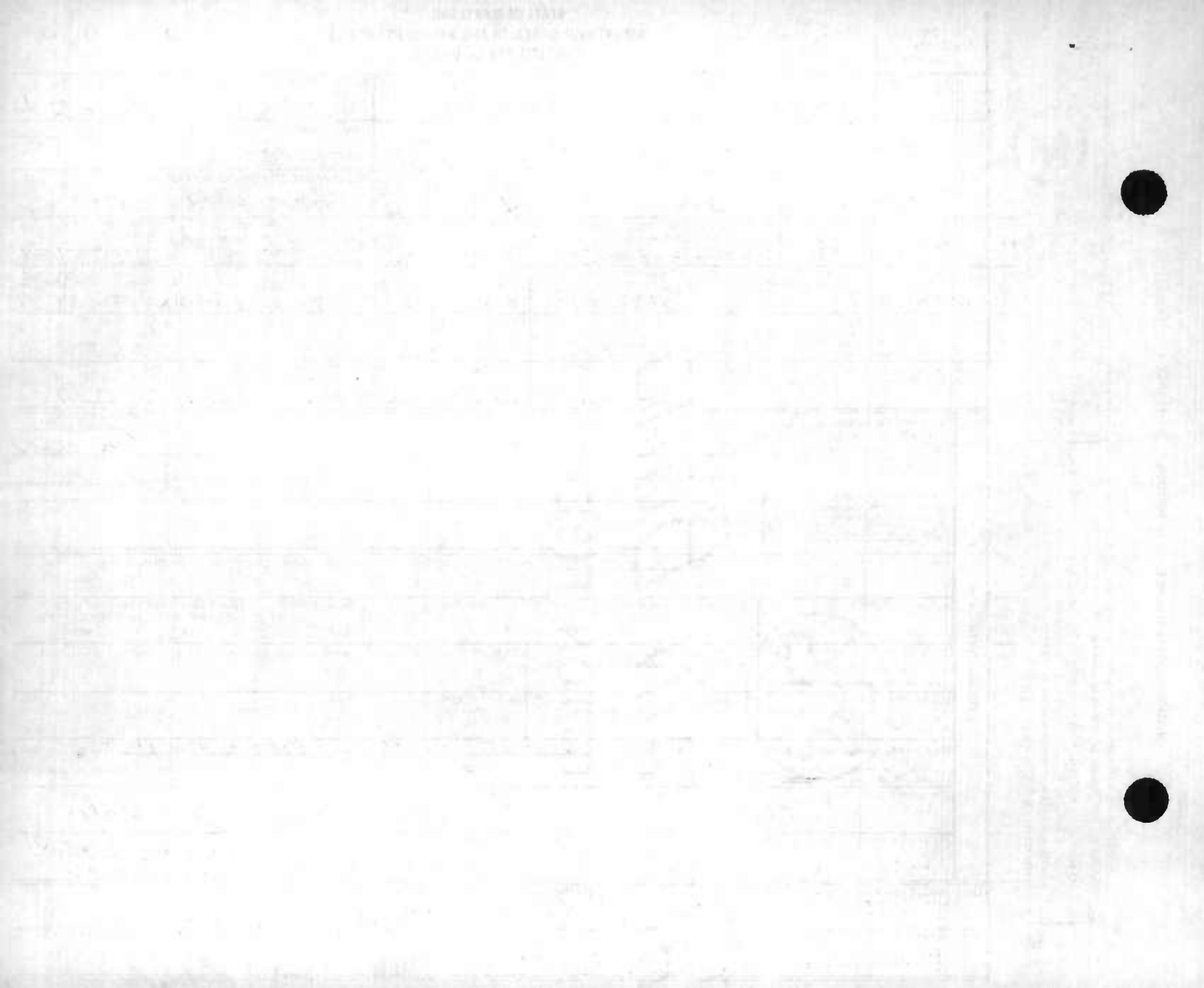
1- FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |  |   |                  |   |
|--|---|---|--|--|--|--|---|------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST   | MIDDLE   | LAST   | 2a. DATE OF DEATH  | MONTH  | DAY   | YEAR             | 2b. HOUR  |
| SOLOMON  |   |   |  | FAIMAN   | MARCH  | 2  | 1981  |                  | 6:32 AM   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |                  |   |
| MALE   | CAUCASIAN   | DAY 1893<br>MONTH AUG YRS XXXX  | 87 XXXX YRS.   |  | MONTHS DAYS  |  | HOURS MIN.  |                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |   |                  |   |
| RUSSIA   | US  |   |  | BALTIMORE CITY MD.   |  |  |   |                  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |   |                  |   |
| BALTIMORE  | LEVINGAVE HEBRON GERIATRIC CENTER + HOSPITAL  |   | SELF-EMPLOYED  |  | CLOTHING/DRY GOODS                                       |  |   |                  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                                      |  |   |                  |   |
| MARYLAND   |   |   | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 1139 E. Lombardy St. #21202                              |  |   |                  |   |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |   |                  |   |
| FIRST MIDDLE LAST<br>ZALMAN  |   | FIRST MIDDLE LAST<br>HAVA UNKNOWN   |  |  |  |  |   |                  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  |  |   |                  |   |
|  |   | 213-34-2780A  |  | MRS. FRIEDA EISENBERG<br>5903 EASTCLIFF DR. BALTO., MD 21209                   |  |  |   |                  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |  |  |  |  |   |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>ONE WEEK |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |  |  |  |  |   |                  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                  |   |
|  |   |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |                  |   |
| 22a. I certify that (this hospital) attended the deceased from OCT-15, 1980, to MARCH 2, 1981, that (we) lost<br>saw the deceased alive on MARCH 2, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above. (we) (did not) view the body after death. |   |   |  |  |  |  |   |                  |   |
| 22b. SIGNATURE   |   |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED |   |
|  |   |   |  |  |  |  |   | 3/2/81           |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |  | 22e. ADDRESS   |  |  |   |                  |   |
| ESTRELLITA O. KN   |   |   |  | LEVINGAVE HEBRON GERIATRIC CENTER + HOSPITAL                                   |  |  |   |                  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |                  |   |
| BURIAL   |   | 3/3/81  |  | OHR KNESSETH ISRAEL  |  | BALTO. MARYLAND  |   |                  |   |
| 24. FUNERAL DIRECTOR   |   |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |   |                  |   |
| SOL LEVINSON & BROS., INC.<br>601 REISTERSTOWN RD. BALTO., MD 21215  |   |   |  | MAR 6 1981   |  |  |   |                  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any.



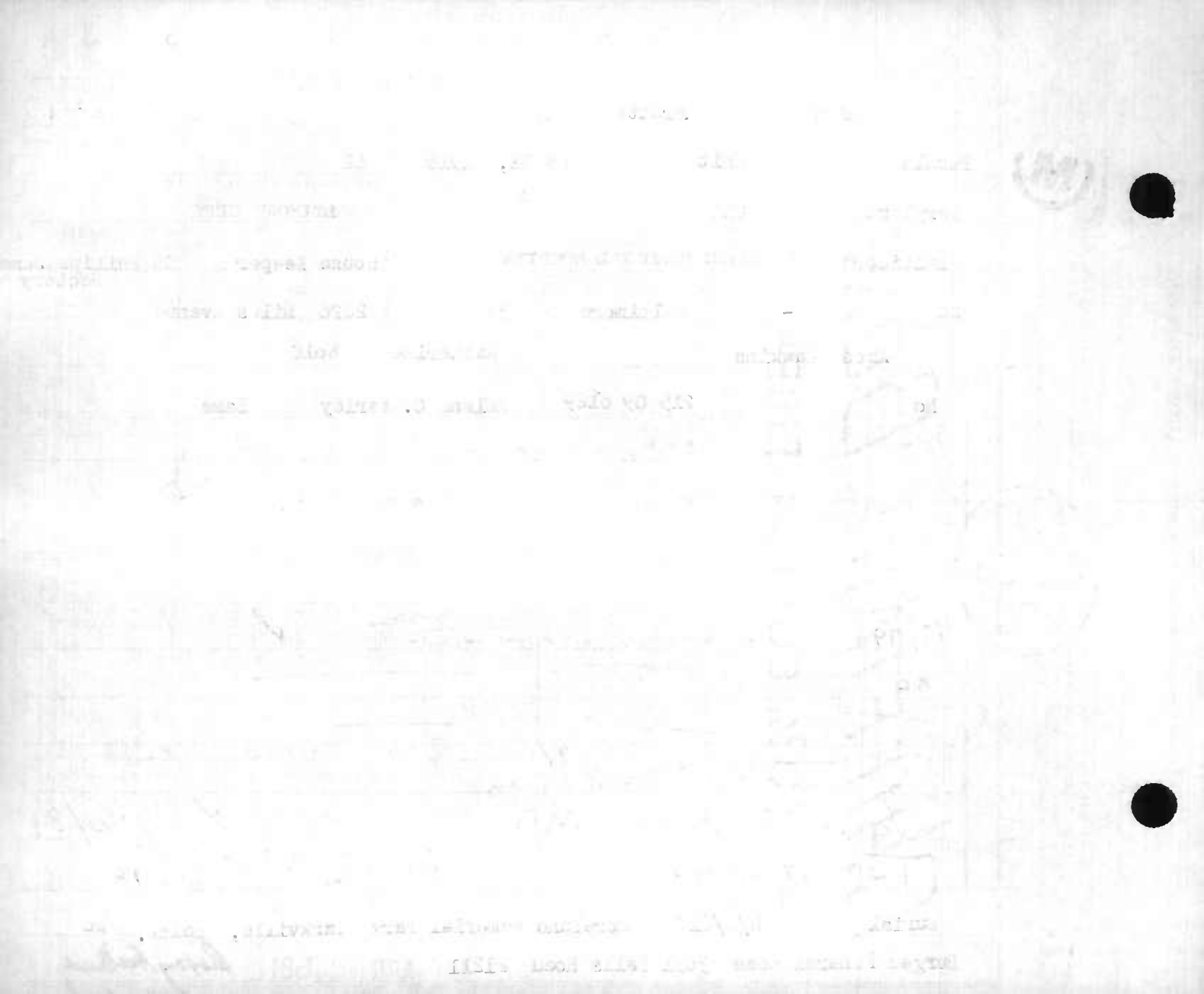
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 6 9 3 4   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY Loretta FARLEY</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-30-81</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 31, 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Keeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SS Philips &amp; Jame Rectory</b>  |  |
| 13a. STATE<br><b>Md</b>  |  |   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Amos Hawkins</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katherine Wolf</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 09 8129</b>  |  | 17. INFORMANT ADDRESS<br><b>Roland C. Farley Same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Advanced Abdominal Carcinomatosis</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Papillary Serous Cyst adenocarcinoma of ovary</b> STAGE IV<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>DEHYDRATION</b> |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/7/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>PAPILLARY SEROUS CYST ADENOCARCINOMA</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>No</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>_____   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>_____   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>_____  |  | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE<br>_____  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/1</b> , 19 <b>79</b> , to <b>3/30</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/30 4Am</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death. <b>DEATH 6:20 AM</b>  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Tom Moran MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>3/30/81</b>  |  | 22d. ADDRESS<br><b>UNION MEMORIAL HOSP 201 UNIV. PKINP BALD MD 21218</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/2/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. H. H.</b>   |  |
| 25c. ADDRESS<br><b>3631 Falls Road 21211</b>   |  |   |  |   |  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 2/80

| 1- STATE REGISTRAR   |  |                         |  |   |  |   |  |  |  | REG. NO. 06935   |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------|--|---|--|---|--|--|--|--|--|---|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Albert Wesley Farris Jr.</b>   |  |                         |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 24 19 81</b> |  |   |  |  | 2b. HOUR <b>M</b>  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>    |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 31, 1926</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55 YRS.</b>                                    |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 24 19 81</b>                     |  |  |  |  | 2d. HOUR <b>11:28 M</b>                       |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b> |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b> |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b> |  |  |   |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>A.A.</b> |  | 13c. CITY OR TOWN <b>Brooklyn</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>4818 Marshall Rd Brooklyn MD</b>  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Wesley Farris Sr.</b>  |  |                         |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ollie Fitzgerald</b>                           |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                         |  | (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO. <b>230-36-2398</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Dau: Mrs. Vickie Lampert</b>                         |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                         |  |   |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt injuries to trunk, extremities and head</b>   |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 8147   |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| (b) <b>DU TO, OR AS A CONSEQUENCE OF</b>   |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| (c) <b>DU TO, OR AS A CONSEQUENCE OF</b>   |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  |   |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  |  |   |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  |   |  |   |  |  |  | 21b. TIME OF INJURY HOUR <b>10:16M</b> MONTH DAY YEAR <b>3 24 19 81</b>                      |  |   |  |  |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Pedestrian struck by motor vehicle</b> |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  |   |  |   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>                      |  |   |  |  |  |  |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Marshall Rd. at 9th Ave., Anne Arundel, Md.</b>                       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                         |  |   |  |   |  |  |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER                                       |  |   |  |  |  |  |   |  |  | DATE SIGNED <b>3-25-81</b>  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                         |  |   |  |   |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                         |  |   |  |   |  |  |  | 23b. DATE <b>3/27/81</b>   |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b> |  |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waynesboro, Virginia</b>   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Waynesboro, Va. 22980</b>   |  |                         |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 9 1981</b>  |  |   |  |  |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL HOME, INC. <b>618 W. Main St.</b>  |  |                         |  |   |  |   |  |  |  |  |  |   |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |  |

983-9248383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Eva Fax</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 15, 1981</b> |   | 2b. HOUR<br><b>1:10P M</b>                   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 1 1904</b>   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>77</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>77</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELSIE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-32-9076T</b>   |  | 17. INFORMANT<br><b>Mr Walter Brown</b>   |  |  |
|  |  |   |  | ADDRESS <b>649 W. LAFAYETTE BALTO, MD.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                       |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitis, Brain tumor</b>  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that I (this hospital) attended the deceased from <b>March 15</b> , 19 <b>81</b> , to <b>March 15</b> , 19 <b>81</b> , that <b>X</b> (we) lost saw the deceased alive on <b>March 15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>X</b> (we) (did not) view the body after death. |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Craig R. Martin</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-15-81</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig R. Martin M.D.</b>   |  | 22e. ADDRESS<br><b>Care of Maryland General Hospital</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/19/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chatman F./H</b>  |  | ADDRESS<br><b>1701 McCulloch St</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b>   |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

BP **5**DHMM-16 30M 2/80  
(VRA 15, 4)



Baltimore Maryland General Hospital

Baltimore City

Myocardial Infarction

Diabetes Mellitus Brain tumor



March 12 1951

Craig H. Martin M.D. Care of Maryland General Hospital

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN L. FEATHERSTONE</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-6-81</b>  |   | 2b. HOUR<br><b>5:45 A</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 14 14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>B+O railroad</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>Balto</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES Featherstone</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Hughes</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unk</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-14-2771</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Gladys Haney 5547 Lothian Road</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Lung cancer</b>   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes</b><br><br><b>months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>Ø</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>1-23</b> , 19 <b>81</b> , to <b>3-6</b> , 19 <b>81</b> , that I (we) lost<br>saw the deceased alive on <b>3-6</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Patricia D. Smith</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3-6-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA D SMITH</b>  |  | 22e. ADDRESS<br><b>Mercy Hospital</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/9/1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1981</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 East North Ave.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

NAME: [illegible]  
ADDRESS: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
ZIP: [illegible]  
DATE: [illegible]  
BY: [illegible]

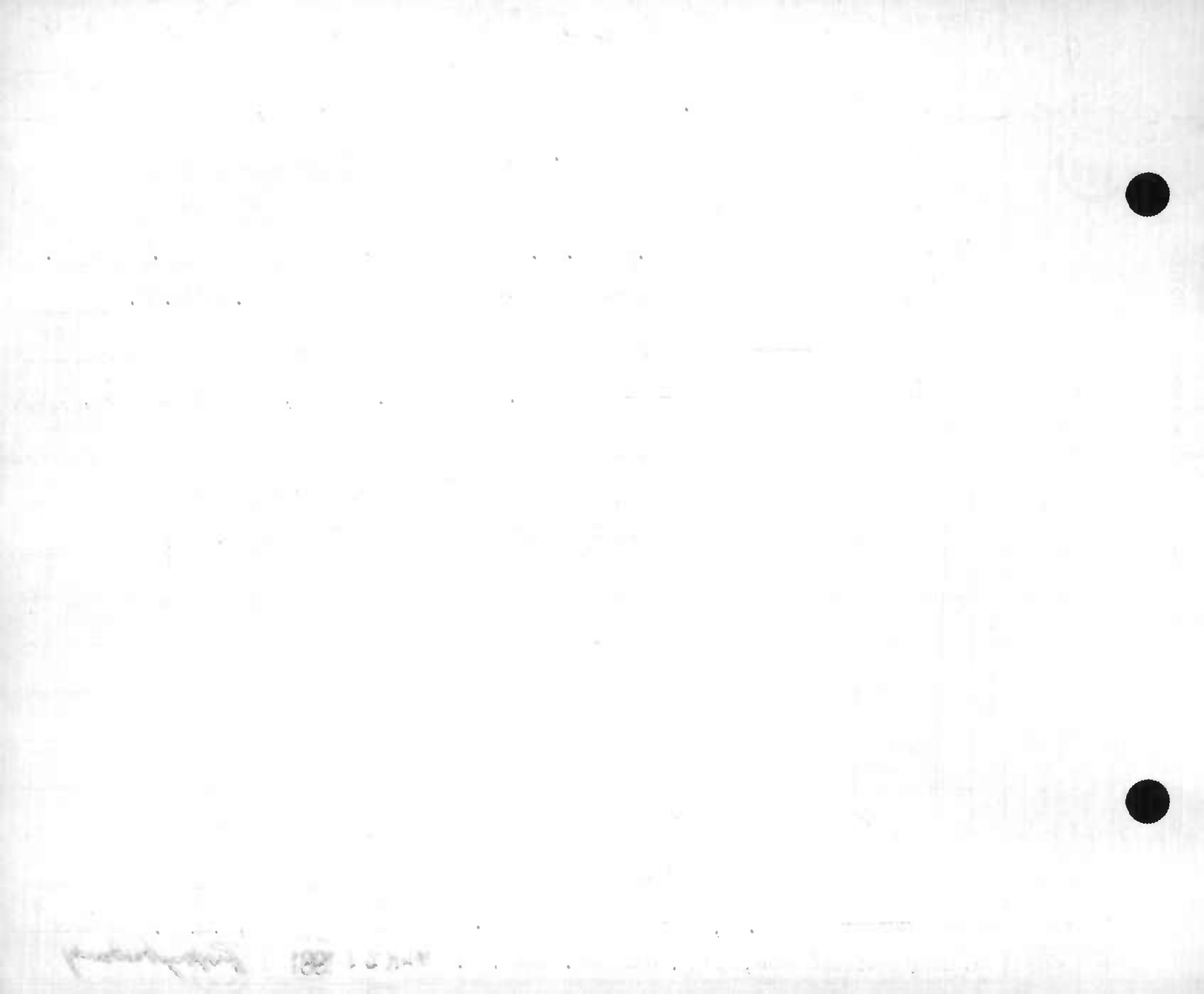
8865 3988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |  |  |  | 8 1 0 6 9 3 8                 |  |
|--|--|--|--|--|---|---|--|--|--|-------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |  |  | REG. NO.                      |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Margaret E. Feehely</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 25, 1981</i>                   |  |   | 2b. HOUR<br>AM PM<br><i>7</i>   |  |  |  |                               |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>White</i>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Jan. 19, 1919</i>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>62</i>                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                      |  |  |  |                               |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>1516 Byrd St. Balto. Md.</i> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Floor Lady</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Md. Glass Co.</i>  |  |                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |  | 13b. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>1516 Byrd St. Balto. Md.</i> |  |  |                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Louis ----- Hahn</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Margaret ----- Connors</i> |  |   |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>212-09-2388</i>                                 |  | 17 INFORMANT<br>ADDRESS<br><i>Mr. Lawrence L. Feehely, 5739 Mineral Ave., 21227</i>             |   |  |  |  |                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>No fatal or contributory conditions</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |   |  |  |  |                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                     |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |  |  |  |                               |  |
| 22b. SIGNATURE<br><i>Marvin J. Feldman</i>   |  |  |  |  |   | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARVIN J. FELDMAN</i>  |  |  |  |  |   | 22e. ADDRESS  |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Entombed</i>  |  |  | 23b. DATE<br><i>Mar. 28, 1981</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem. Park</i>                               |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Glen Burnie, A. A. Co. Maryland</i>   |  |                               |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>McCurly Funeral Home, 130 E. Port Ave. Balto. Md.</i>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 27 1981</i>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |                               |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
|---|--|------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--------------------|--|-------------------------|--|
| 1- FOR STATE REGISTRAR  |  |                  |  |  |  |   |  |   |  | 06939  |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CINDY ANTHONY S. FEESER   |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3 29 19 81     |  |   |  |  |  |  |  |  |  | 2b. HOUR<br>M<br>M |  |                         |  |
| 3. SEX<br>female  |  | 4. RACE<br>white |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 27 63   |  | 6. AGE (IN YEARS) LAST BIRTHDAY<br>17 YRS.                          |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>3 29 19 81   |  |  |  |  |  |  |  |                    |  | 2d. HOUR<br>p M<br>8:13 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Hanover, Pa.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |  |  |  |  |                    |  |                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |  |  |  |                    |  |                         |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE CITY COUNTY<br>Md. Carroll Millers   |  |                  |  |  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br>Hoffmanville Road  |  |  |  |  |  |  |  |                    |  |                         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert E. Feeser   |  |                  |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Rill                                    |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>no  |  |                  |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>217-80-7109                             |  |   |  | 17. INFORMANT ADDRESS<br>Mr. Robert Feeser, Millers, Md.                                     |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>8123<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                  |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |  |  |  |  |                    |  |                         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| 19a. DATE OF OPERATION  |  |                  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |   |  |  |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                    |  |                         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  |  |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR<br>7 P.M. 3-29-1981    |  |   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Passenger in motorcycle/pick-up truck collision. |  |  |  |  |  |  |  |                    |  |                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road |  |   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>Hanover Pike near Lee's Mill Rd. Balto. Md.                                     |  |  |  |  |  |  |  |                    |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.  |  |                  |  |  |  |   |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>3-30-81   |  |  |  |  |  |                    |  |                         |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |                  |  |  |  | ADDRESS<br>111 Penn St.   |  |   |  |  |  |   |  |  |  |  |  |  |  |                    |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |  |  |  | 23b. DATE<br>4-1-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Shiloh Cemetery   |  |  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hampstead Carroll Md. |  |  |  |  |  |                    |  |                         |  |
| 24. FUNERAL DIRECTOR NAME<br>Eline Funeral Home, Hampstead, Md.   |  |                  |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 3 1981  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |  |  |  |  |  |                    |  |                         |  |

MEDICAL CERTIFICATION



[Faint, mostly illegible text and markings, possibly a header or address block.]

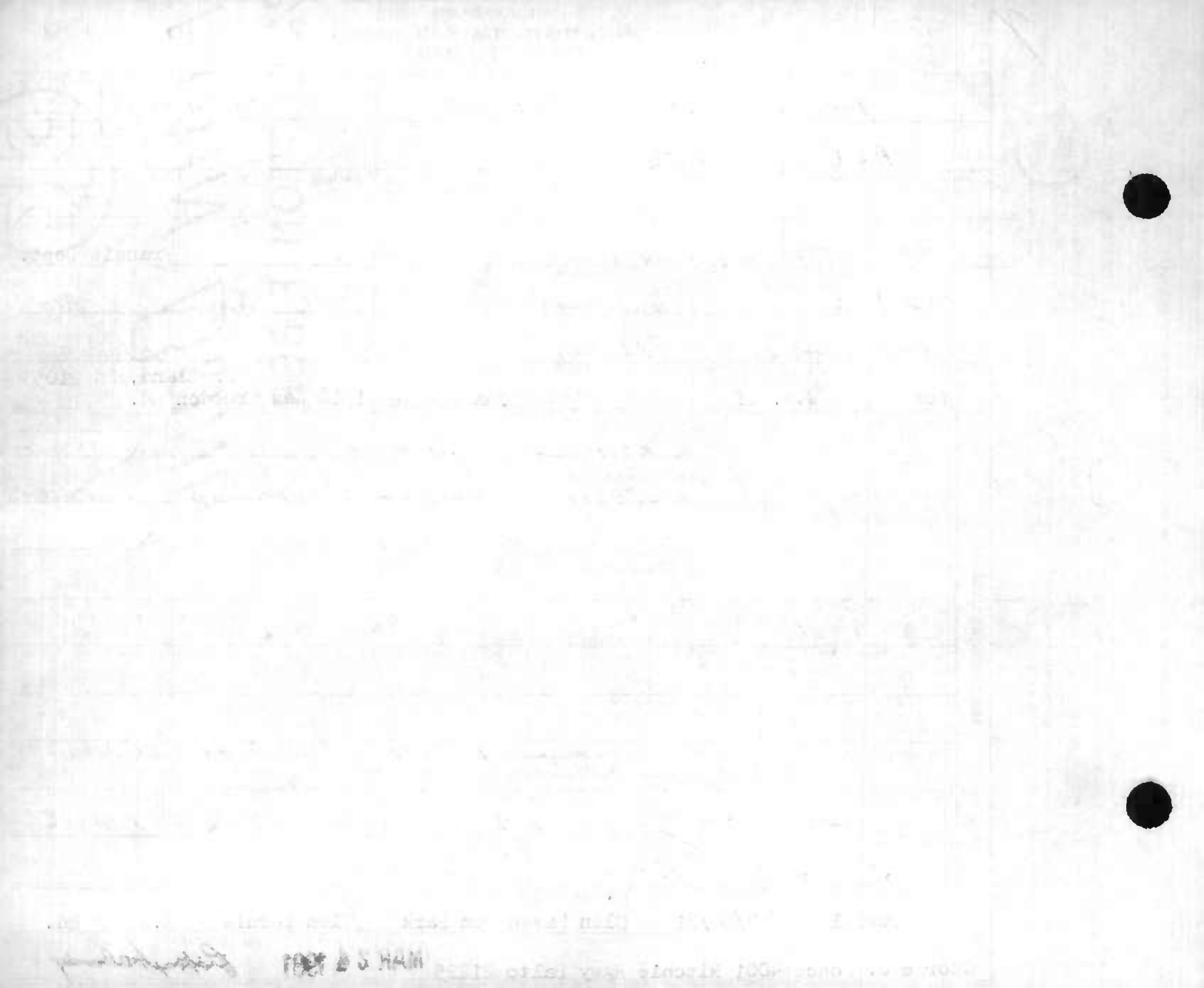
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |                                   |   |  |   |                                      |  | 8 1 0 6 9 4 0                     |  |
|--|--|--|--|-----------------------------------|---|--|---|--------------------------------------|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |                                   | REG. NO.  |  |   |                                      |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |                                   | 2a. DATE OF DEATH   |  |   |                                      |  | 2b. HOUR                          |  |
| FIRST MIDDLE LAST<br><u>HOWARD E. G. FELLING</u>   |  |  |  |                                   | MONTH DAY YEAR<br><u>MARCH 21 81</u>  |  |   |                                      |  | <u>3<sup>15</sup> AM</u>          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH                  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| <u>MALE</u>  |  | <u>White</u>   |  | MONTH DAY YEAR<br><u>03 06 07</u> |   |  | <u>74</u> YRS.  |                                      |  | IF UNDER 24 HRS.<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                   |  |
| <u>MD</u>  |  | <u>U.S.A.</u>  |  |                                   |   |  |   | <u>BALTIMORE CITY MD.</u>            |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| <u>BALTIMORE</u>   |  | <u>South BALTIMORE GEN. HOSP.</u>  |  |                                   |   |  | <u>Driver</u>   |                                      |  | <u>Transit Dept.</u>              |  |
| 13a. STATE   |  |  | 13b. COUNTY  |                                   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |                                      | 13e. STREET ADDRESS  |                                   |  |
| <u>MD</u>  |  |  |  |                                   | <u>BALTIMORE</u>  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | <u>4192 TOWNSEND AVE.</u>                                      |                                   |  |
| 14. FATHER'S NAME  |  |  |  |                                   | 15. MOTHER'S MAIDEN NAME  |  |   |                                      |  |                                   |  |
| FIRST MIDDLE LAST<br><u>CHRISTOPHER FELLING</u>  |  |  |  |                                   | FIRST MIDDLE LAST<br><u>JUGIA BISHOP</u>  |  |   |                                      |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |                                   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |                                      |  |                                   |  |
| <u>Yes</u>   |  |  |  |                                   | <u>W.W. II</u>  |  | <u>Edna Krause 21518 New Freedom Rd.</u>                            |                                      |  |                                   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br><u>1991</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC MALIGNANT CARCINOMA</u><br>Tumor<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>infiltrating malignant carcinoma Terminal Neuron</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10-15 min</u><br><u>unknown</u> |  |  |  |                                   |   |  |   |                                      |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |                                   |   |  |   |                                      |  |                                   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED     |                                   |   |  | 20a. AUTOPSY?   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
| <u>3-7-81</u>  |  |  | <u>Perforation duodenal ulcer with metastatic ca</u> |                                   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                                  |                                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                                      |  |                                   |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |                                   |   |  |   |                                      |  |                                   |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                                 |                                   |   | 21f. LOCATION  |   |                                      | CITY OR TOWN COUNTY STATE                                      |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |                                   |   | STREET   |   |                                      |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 7<sup>th</sup></u> , 19 <u>81</u> , to <u>March 21</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |                                   |   |  |   |                                      |  |                                   |  |
| 22b. SIGNATURE   |  |  |  |                                   |   |  |   | DEGREE                               |  | 22c. DATE SIGNED                  |  |
| <u>Badro</u>   |  |  |  |                                   |   |  |   | <u>MD</u>                            |  | <u>3-21-81</u>                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |                                   |   |  |   | 22e. ADDRESS                         |  |                                   |  |
| <u>NABIL BADRO</u>   |  |  |  |                                   |   |  |   | <u>SBGH</u>                          |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |                                   | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION                        |  | CITY OR TOWN COUNTY STATE         |  |
| <u>Burial</u>  |  |  | <u>3/24/81</u>                                       |                                   | <u>Glen Haven Mem Park</u>  |  |   | <u>Glen Burnie</u>                   |  | <u>A.A. Md.</u>                   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |                                   |   |  |   | 25a. DATE REC'D. BY REGISTRAR        |  | 25b. REGISTRAR'S SIGNATURE        |  |
| NAME ADDRESS<br><u>George J. Gonca 4001 Ritchie Hwy Balto 21225</u>  |  |  |  |                                   |   |  |   | <u>MAR 24 1981</u>                   |  | <u>[Signature]</u>                |  |



1987 23 JAN

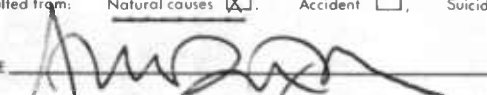

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>KATHRYN  |  | MIDDLE<br>MARGARET  |  | LAST<br>FENTON                           |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> 3 13 1981 |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>female   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jul 31 1904   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>76 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS            |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br>3 16 1981   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  | MD.                                      |  | 24. HOUR<br>12:07  |  | M   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>900 Cathedral St.  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>unknown   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>-   |  |  |  |  |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br>900 Cathedral St. |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Koehler  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel -   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>330-14-5696   |  | 17. INFORMANT<br>Wm. Hoerr (cousin)      |  | ADDRESS<br>2104 Durham Rd.   |  |   |  |
| MEDICAL CERTIFICATION  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive &amp; arteriosclerotic cardiovascular disease</u><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |
|  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |   |  |   |  |  |  |  |  |   |  |
|  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |  |  |  |  |   |  |
| ACTUAL<br>SIGNATURE<br>   |  | M.D. Assistant   |  | MEDICAL EXAMINER  |  | DATE<br>SIGNED 3-16-81  |  |  |  |  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  | ADDRESS<br>111 Penn St.  |  |   |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br>3/19/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |  |  |   |  |
| 24. FUNERAL HOME<br>NAME<br>Sankhurek Funeral Home, Inc.   |  | ADDRESS<br>3331 Brehms Lane<br>Balto. Md. 21213  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |  |  |   |  |

1102



*[Handwritten signature]*

*[Handwritten signature]*

1967 JUN 20 10 10 AM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 4 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Betty Lou Fey</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>17</b> YEAR <b>1981</b>                          |  | 2b. HOUR<br><b>9:49am</b>                      |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>Oct</b> DAY <b>24</b> YEAR <b>1928</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                     |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13c. STREET ADDRESS<br><b>Box 96</b>   |  |
| 14. FATHER'S NAME<br><b>Thomas</b> MIDDLE <b>Sloan</b> LAST <b>Mayo</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Irene</b> MIDDLE <b>Wischer</b> LAST <b>Wischer</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>813-24-5971</b>  |   | 17. INFORMANT<br><b>Stanley W. Fey #13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>① heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARDS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>3 wks</b><br><b>3 wks</b> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>laryngeal carcinoma</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>2-26-81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>laryngeal ca.</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3-15</b> 19 <b>81</b> , to <b>3-17</b> 19 <b>81</b> , that (1) (we) lost<br>saw the deceased alive on <b>3-17</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Michael Hausknecht</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3-17-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAUSKNECHT</b>  |  | 22e. ADDRESS<br><b>601 N. BROADWAY 21205</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Crementation</b>   |  | 23b. DATE<br><b>3/19/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Brentwood P.B. MD.</b>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Taylor &amp; Sons</b>  |  | ADDRESS<br><b>Annapolis MD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>                                  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>   |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |                            |  |  | 8106943  |  |
|---|--|--|--|---|--|---|----------------------------|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |  |  |   |  |   |                            |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Rosalee</i> <i>Fields</i>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3</i> <i>1</i> <i>81</i> |   | 2b. HOUR<br><i>1:20</i> PM |  |  |  |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>B</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10</i> <i>20</i> <i>29</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>51</i> YRS.   |                            | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>0</i> <i>0</i>  |  | 7. UNDER 24 HRS<br>HOURS MIN.<br><i>0</i> <i>0</i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.   |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>UNIV. OF MD. HOSP.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>unemployed</i>           |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>—</i>  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |                            |  |  |  |  |
| 13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY<br><i>—</i>  |  | 13c. CITY OR TOWN<br><i>BALT.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | 13e. STREET ADDRESS<br><i>615 CUMBERLAND ST</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>ED</i> <i>FLETCHER</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ETTA</i> <i>FLETCHER</i>  |  |   |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>UNKNOWN</i>  |  |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>27-24-8586</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>SELF @ time of registration</i>                                  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>CARDIO-PULMONARY ARREST</i><br><i>2390</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>TERMINAL PANCREATIC DISEASE</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <i>—</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 min.</i><br><i>1 mon.</i> |  |  |  |   |  |   |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)   |  |  |  |   |  |   |                            |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>2-11-81</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>pancreatic mass, intestinal obs.</i>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>—</i> <i>—</i> <i>—</i> <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21</i> , 19 <i>81</i> , to <i>MARCH 1</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>MARCH 1</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |                            |  |  |  |  |
| 22b. SIGNATURE<br><i>Louis W. Solomon</i>   |  |  |  | DEGREE<br><i>MD</i>   |  |   |                            | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3-1-81</i>                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Louis W. Solomon</i>  |  |  |  | 22e. ADDRESS<br><i>22 S. GREENE ST. Baltimore Md. 21201</i>   |  |   |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-5-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>KING MEMPK</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>RANDALLSTOWN Md.</i>                           |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>JAS. A. MORTON &amp; SONS</i>  |  |  |  | ADDRESS<br><i>1701 Laurans ST.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 5 1981</i>  |                            | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony KeBuddy</i>   |  |  |  |

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KING OF THE HILL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>8 1 0 6 9 4 4<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR<br>AKA- CAZIMIERA KLAMUT FILAR   |  |   |  |   | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>KAZIMIERA FILAR  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 1 81                                  |  |  | 2b. HOUR<br>1 45 P M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 14 1890  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Poland  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Elkridge   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory Worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Langs Packing Co.   |  |
| 13a. STATE<br>Maryland  |  |   |  |   | 13b. CITY OR TOWN<br>Elkridge  |  | 13c. STREET ADDRESS<br>Elkridge, Md. 21227<br>6180 Old Washington Road         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jan Klamut  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Teofila Laszewska             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>212-03-2074  |  | 17. INFORMANT<br>ADDRESS<br>Tadeus S. Filar 5713 Leaf Lane Elkridge, Md. 21227 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4100 IMMEDIATE CAUSE (a) Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) ASCVD generalized<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Victor Jaworsky   |  |   |  |   | DEGREE   |  |  | 22c. DATE SIGNED<br>5/1/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Victor Jaworsky  |  |   |  |   | 22e. ADDRESS<br>St. Agnes Hospital<br>900 Calver Street, Baltimore, Maryland   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/5/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1981                                    |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McBrady                                  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|---|--|--|
| FOR<br>1 - STATE REGISTRAR   |  |  |  |  | 8 1 0 6 9 4 5<br>CERTIFICATE OF DEATH        |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH                            |  |   |  |  |
| ROSE FINK  |  |  |  |  | 3/20/81                                      |  |   |  |  |
| 2. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 2b. HOUR   |  |
| FEMALE   |  | CAUCASIAN  |  | 12 18 1895   |  | 85 YRS.  |   | 430 A.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| MARYLAND   |  | USA  |  |  |  | BALTIMORE CITY MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK AND NATURE OF WORKING LIFE)                |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | LEVINDALE HEBREW GERIATRIC   |  |  |  | WRAPPER  |   | DEPT. STORE  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |   |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS  |  |
| MARYLAND   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 3636 FORDS LA., 1st fl. 21215                                  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                     |  |   |  |  |
| JACOB FINK   |  |  |  |  | BESSIE HYMAN                                 |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.                     |  | 17. INFORMANT                                       |  |  |
| NO   |  |  |  |  | 220-44-5973                                  |  | MR. HERBERT FINK<br>601 LENNOX ST. BALTO., MD 21217 |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>HRS. |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>DEC. 15</u> , 19 <u>80</u> , to <u>MARCH 20</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>MARCH 20</u> , 19 <u>81</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.   |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE                                       |  | 22c. DATE SIGNED                                    |  |  |
| <u>Estrelita O. Kw</u>   |  |  |  |  |  |  | 3/20/81   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS                                 |  |   |  |  |
| ESTRELITA O. KW  |  |  |  |  | LEVINDALE HEBREW GERIATRIC CENTER + HOSPITAL |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN   |   | 23e. STATE   |  |
| BURIAL   |  | 3/22/81  |  | BNAI ISRAEL  |  | BALTIMORE  |   | MARYLAND   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |  |  | MAR 26 1981  |   | <u>Robert M. Brady</u>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ESTHER</b>   |  | FIRST<br><b>FINKELSTEIN</b>  |  | LAST  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 24 1981</b>   |  | 2b. HOUR<br><b>10:45 AM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 16 1908</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br><b>LEVINTALE HEBREW GERIATRIC CENTER + HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESPERSON</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHING</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM WEIS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA JACOBS</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>119-01-3721</b>   |  | 17. INFORMANT<br><b>DIANE FINKELSTEIN ROSEN</b><br><b>4001 CLARKS LA., APT. 209 BALTO., MD 21215</b>   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1629 LUNG CA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>MONTHS</b>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/20</b> , 19 <b>81</b> , to <b>3/24</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>3/24</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Estrelita O. Ku</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/24/81</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KU</b>  |  | 22e. ADDRESS<br><b>LEVINTALE HEBREW GERIATRIC CENTER + HOSPITAL</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/25/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH BETH ISRAEL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |  |   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



RECEIVED  
IN THE OFFICE OF THE  
SECRETARY OF THE  
NAVY

1. The first part of the report is a summary of the work done during the year. It is divided into two main sections, the first of which deals with the general work of the office and the second with the work of the various divisions. The first section is divided into three parts, the first of which deals with the general work of the office, the second with the work of the various divisions, and the third with the work of the various divisions. The second section is divided into two parts, the first of which deals with the work of the various divisions and the second with the work of the various divisions.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 4 7

REG. NO.

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Dennis Allen Finn                   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>3 3 81                   |  |  | 2b HOUR<br>4:59 PM   |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 7 44  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS   |  | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALT                          |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>City- MD  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>H. of H. D Hosp - |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Rep.                  |  | 12b KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a STATE<br>MD   |  | 13b COUNTY<br>Balto.  |  | 13c CITY OR TOWN<br>Baldwin  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br>2905 Blythe Ct                         |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>William T Finn                   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dorothy V Hays |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |  |   | 16b SOCIAL SECURITY NO<br>219 445720                           |  |  | 17 INFORMANT<br>Wife - Same -  |  |  |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY:

4300

IMMEDIATE CAUSE (a)

Cardio Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Intracerebral Hematoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cerebral Artery Aneurysm

APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH

21 days

21 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a DATE OF OPERATION<br>3/2/81  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aneurysm -        |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from 2/3 19 81 to 3/3 19 81, that (I) (we) last saw the deceased alive on 3/3 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) |  |  |  |  |  |   |  |
| 22b SIGNATURE<br>H.D.  |  | DEGREE<br>H.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>3/3/81   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Machado  |  |  |  | 22e ADDRESS<br>H. of H. D Hosp -   |  |   |  |

|   |  |                      |  |  |  |  |  |
|---|--|----------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                          |  | 23b DATE<br>3/7/1981 |  | 23c NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cem. |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto. Md. |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>J. E. Lowell Lemmon 10 W. Padonia Rd |  |                      |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 6 1981               |  | 25b REGISTRAR'S SIGNATURE<br>[Signature]                             |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 1 0 6 9 4 8  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR   |  |
| Catherine C Finnegan   |  |  |  |  |  |  |  |  |  | 3 17 1981  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |
| F Female   |  |  |  |  |  |  |  |  |  | Cauc.  |  |
| 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | YRS.   |  |
| 12 31 1899   |  |  |  |  |  |  |  |  |  | 81   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| XXXXXX Md.   |  |  |  |  |  |  |  |  |  | U.S.A.   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Baltimore City   |  |  |  |  |  |  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |
| Baltimore  |  |  |  |  |  |  |  |  |  | UNION MEMORIAL   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Retired  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |
| 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |
| Baltimore  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS  |  |  |  |  |  |  |  |  |  | 2808 E. Baltimore St.  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  | FIRST MIDDLE LAST  |  |
| Owen Finnegan  |  |  |  |  |  |  |  |  |  | Catherine Hopf   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |
| No   |  |  |  |  |  |  |  |  |  | 218-22-2207  |  |
| 17. INFORMANT  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |
| Jean Finnegan  |  |  |  |  |  |  |  |  |  | 2808 E. Baltimore St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | 1749   |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | RESPIRATORY FAILURE  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  | CARCINOMA R BREAST   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 3-17-81  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |
|  |  |  |  |  |  |  |  |  |  | P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
|  |  |  |  |  |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 19 81, to MAR 4 19 81, that (I) (we) lost saw the deceased alive on FEB 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE   |  |
|  |  |  |  |  |  |  |  |  |  | DEGREE   |  |
|  |  |  |  |  |  |  |  |  |  | MD   |  |
| 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |
| FRANCIS X CARMODY  |  |  |  |  |  |  |  |  |  | 3201 N CHARLES ST.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 3/21/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| New Cathedral Cem.   |  |  |  |  |  |  |  |  |  | Baltimore MD.  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| B. Dabrowski & Son 2818 E. Baltimore St.   |  |  |  |  |  |  |  |  |  | MAR 20 1981  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |

BP

DHMH-16 30M 2/80  
(VRA 15, 4)



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 4 9

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR <i>Reba</i>   |  | 2a. DATE OF DEATH MONTH DAY YEAR 3 4 81  |  | 2b. HOUR 5 PM  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Reba</i>   |  | MIDDLE <i>Finnery</i>  |  | LAST <i>Finnery</i>  |  |
| 3. SEX <i>Female</i>   |  | 4. RACE <i>Cauc.</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 11 XXXX 03   |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>   |  | 10. USUAL RESIDENCE (TYPE OF WORK OR MOST OF LIVING LIFE) <i>XXXXXX XXXX</i>   |  | 11. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>  |  |
| 12. CITY OR TOWN OF DEATH <i>Baltimore</i>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Senai Hosp.</i>  |  | 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>MD</i>  |  |
| 15. STATE <i>MD</i>  |  | 16. COUNTY <i>Baltimore</i>  |  | 17. CITY OR TOWN <i>Balt</i>   |  |
| 18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 19. STREET ADDRESS <i>7000 FIELDCREST RD.</i>  |  | 20. # <i>21215</i>   |  |
| 21. FATHER'S NAME FIRST MIDDLE LAST <i>DAVID</i>   |  | 22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH UNKNOWN</i>  |  | 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>   |  |
| 24. SOCIAL SECURITY NO. <i>213-18-1946</i>   |  | 25. INFORMANT <i>NATHAN TEXER</i>  |  | 26. ADDRESS <i>7000 FIELDCREST RD., 1ST FL. #21215</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac-pulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal &amp; liver failure, sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>same</i> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |
| 19a. DATE OF OPERATION <i>2-21-81</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lg. Bowel obstruction</i>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21g. I certify that (I) (this hospital) attended the deceased from <i>2-21</i> , 19 <i>81</i> , to <i>3/4</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3-4</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22a. SIGNATURE <i>Marvin A. Kohn MD</i> DEGREE <i>MD</i>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARVIN A. KOHN</i>  |  | 22c. ADDRESS <i>Senai Hosp.</i>  |  | 22d. DATE SIGNED <i>3/4/81</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>  |  | 23b. DATE <i>3/6/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>PROGRESSIVE BENEFIT &amp; RELIEF ASSOC.</i>  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>RANDALLSTOWN BALTO. MD</i>  |  | 24. FUNERAL DIRECTOR'S NAME <i>SOY LEVINSON &amp; BROS., INC.</i>  |  | 25. DATE REC'D. BY REGISTRAR <i>MAR 11 1981</i>  |  |
| 26. ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  | 27. REGISTRAR'S SIGNATURE <i>Robert McCreary</i>   |  |  |  |





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

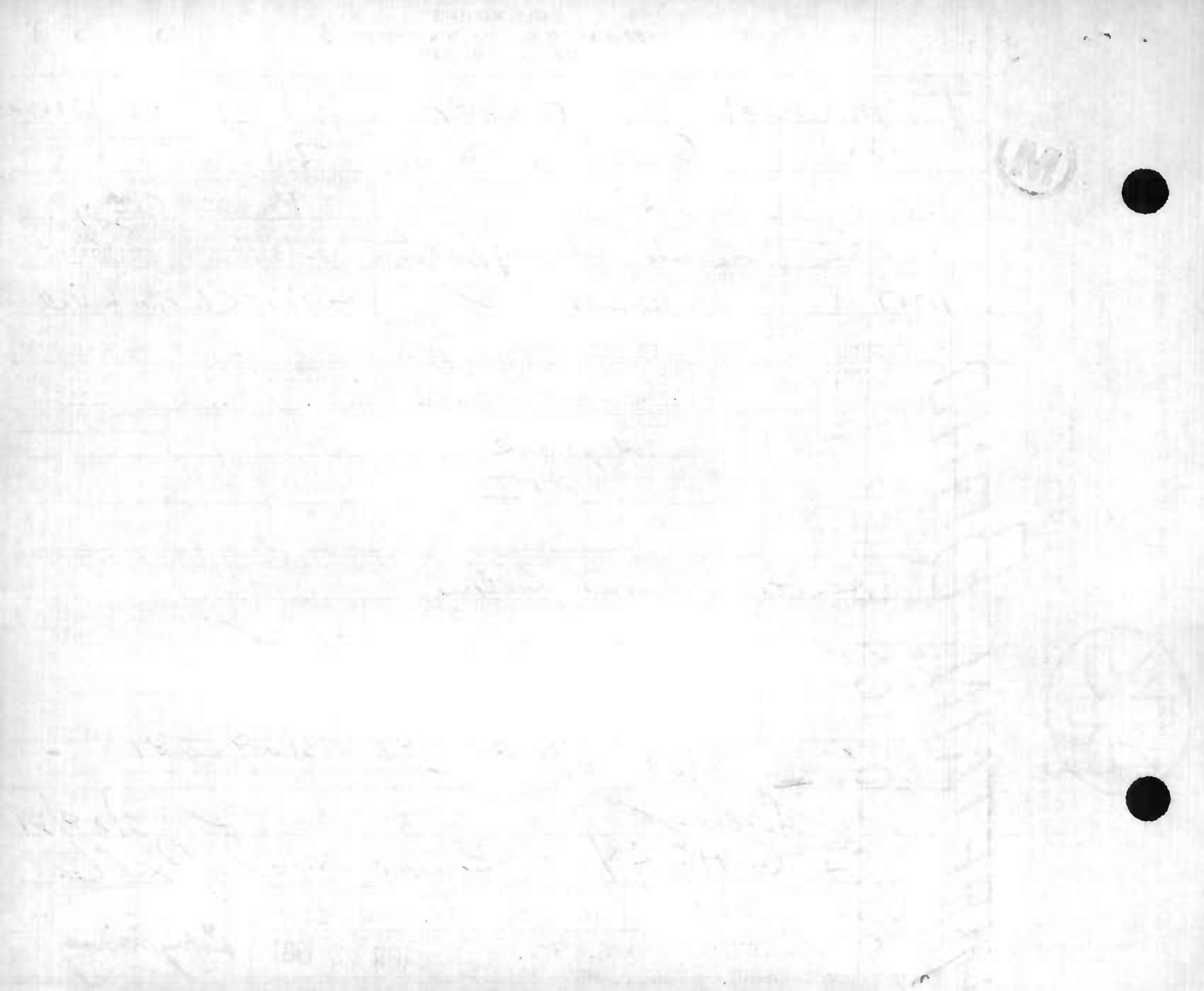
1 - FOR  
STATE  
REGISTRAR

|   |  |   |   |  |                            |  |  |
|---|--|---|---|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Michael Fisher</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 / 29 / 81</i> |  | 2b. HOUR<br><i>12 Noon</i> |  |  |
| 3 SEX<br><i>MALE</i>  |  | 4 RACE<br><i>CAUCASIAN</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 / 19 / 01</i>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD</i>   |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Shirley Hosp of Baltimore</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SELF-EMPLOYED</i>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>WHOLESALE/</i>   |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>BALTIMORE</i>   |   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>JOSEPH FISHER</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>ANNA UNKNOWN</i>  |   | 13e. STREET ADDRESS<br><i>3915 Clarinth Rd.</i>  |                            | MDSE   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>219-50-4105</i>  |   | 17 INFORMANT<br><i>MRS. FRIEDA FISHER</i>  |                            | 17 ADDRESS<br><i>3915 CLARINTH RD. BALTO., MD 21215</i>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Sepsis</i><br><i>5990</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>UTI</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |   |  |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Acute renal failure</i>   |  |   |   |  |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |  |  |
| 22a. I certify that (this hospital) attended the deceased from <i>3/12</i> , 19 <i>81</i> , to <i>3/29</i> , 19 <i>81</i> , that (I) <del>lost</del> <i>saw</i> the deceased alive on <i>3/29</i> , 19 <i>81</i> , and that (my) <del>own</del> <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <del>will</del> <i>will</i> view the body after death. |  |   |   |  |                            |  |  |
| 22b. SIGNATURE<br><i>David G. Aisley</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                            | 22c. DATE SIGNED<br><i>3/29/81</i>   |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br><i>DAVID G. AISLEY</i>   |  |   |   | 22e. ADDRESS<br><i>Shirley Hosp of Baltimore</i>   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>3/31/81</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>OHEB SHALOM MEM. PARK</i>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>REISTERSTOWN BALTO MD</i>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 02 1981</i>  |                            |  |  |
| 25b. ADDRESS<br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>   |  |   |   |  |                            |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral home. The death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 212-639-1234.





Item 23a g554 4/1/81 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8106951

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |   |  |   |                 |                                   |                 |
|---|---|--|---|--|---|-----------------|-----------------------------------|-----------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR        |                                   |                 |
| FIRST MIDDLE LAST<br>Pearl Anita Fitzgerald   |   |  | MONTH DAY YEAR<br>3/27/81   |  |   | 12:10 PM        |                                   |                 |
| 3 SEX   | 4 RACE  | 5 DATE OF BIRTH  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |   | IF UNDER 1 YEAR |                                   | IF UNDER 24 HRS |
| Female  | Black   | MONTH DAY YEAR<br>4 20 1920  | 60 YRS.   |  |   | MONTHS DAYS     |                                   | HOURS MIN.      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |   |                 |                                   |                 |
| Maryland  | U. S. A.  |  |   | Baltimore City MD.   |   |                 |                                   |                 |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   |                 | 12b. KIND OF BUSINESS OR INDUSTRY |                 |
| Baltimore   | Provident Hospital  |  |   | Payroll-Supr.  |   |                 | Dept. SS er.                      |                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |   |  |   |  |   |                 |                                   |                 |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |   |                 |                                   |                 |
| Maryland  |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Maryland 21215<br>3600 Rosedale Road, Balto.                     |   |                 |                                   |                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                       |  |   |                 |                                   |                 |
| Bernard Aquilla   |   |  | Frances Young   |  |   |                 |                                   |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                                     |                 |                                   |                 |
| No  |   |  | 217-16-5915   |  | Balto., Md. 21215<br>Mr. Edward A. Fitzgerald-Rosedale Rd |                 |                                   |                 |

|  |  |   |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock -</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD, DM, Sarcoidosis -</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Recent MI</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended/the deceased from <u>9/30/81</u> 19 <u>81</u> to <u>3-27</u> 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/2/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>C. N. Nijjar</u><br>DEGREE                        |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/27/81                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. S. Nijjar  |  | 22e. ADDRESS<br>2600 Liberty Heights Ave                               |  |  |  |   |  |

|  |                     |   |   |
|--|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial         | 23b. DATE<br>4-1-81 | 23c. NAME OF CEMETERY OR CREMATORY<br>Louden Memorial Pk. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>City Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter Funeral Home |                     | 25. DATE REC'D. BY REGISTRAR<br>MAR 31 1981               |   |
| 26. ADDRESS<br>3035 W. North Ave.                              |                     | 27. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>           |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

10-1-81  
10-1-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillian Fletcher   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 19, 1981   |   | 2b. HOUR<br>10:10PM   |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 28, 1900   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF BUSINESS OR SERVICE)<br>Retired                               | 12b. KIND OF BUSINESS OR SERVICE<br>BUSINESS  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |   |
| 13a. STATE<br>Md.   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>4211 Chatham Rd. 21207   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rodney Fletcher   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Missouri Smith                                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>-----0-----   |  | 16b. SOCIAL SECURITY NO.<br>212-14-0211   | 17. INFORMANT<br>ADDRESS<br>Gloria Muldrew, 4211 Chatham Rd. 21207                              |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4415 IMMEDIATE CAUSE (a) Ruptured Aortic Atherosclerotic ANEURYSM<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Left Ventricular Hypertrophy<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |
| 19a. DATE OF OPERATION  |  |   |   |   |   |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from March 19, 1981, to March 19, 1981, that (we) lost saw the deceased alive on March 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.   |  |   |   |   |   |
| 22b. SIGNATURE<br>Eugenio Machado   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   | 22c. DATE SIGNED<br>3/20/81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eugenio Machado, M.D.  |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br>Burial  |  | 23b. DATE<br>3/25/81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Law Funeral Home 4611 Prk Heights Ave.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                         |

MEDICAL CERTIFICATION

NEW GENERAL BONDING CO. 4011 1/2 W. BELT AVE.

1713

[11] 50:3

Analysis was done with SPSS 16.0 software.

Eugenio Lachdo, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO.                                     |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Angela L. Flowers</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3-7-81</b>  |  | 2b. HOUR<br><b>8<sup>50</sup> A M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 27, 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vincent Kwaitkowski</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emelia Piskorski</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 34 1023</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Josephine Smallwood Same as 13 e</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5860 renal failure</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____              |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>diabetes mellitus hydrocephalus</b>  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 23</b> , 19 <b>81</b> , to <b>March 7</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>March 7</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Barton Hershsfield</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-7-81</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Barton Hershsfield</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>Univ. of Md Hospital - Family Health</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/10/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Park</b>               |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hwy Balto. Md.</b>   |  |   |  |   |  |  |  |   |  |  |  |

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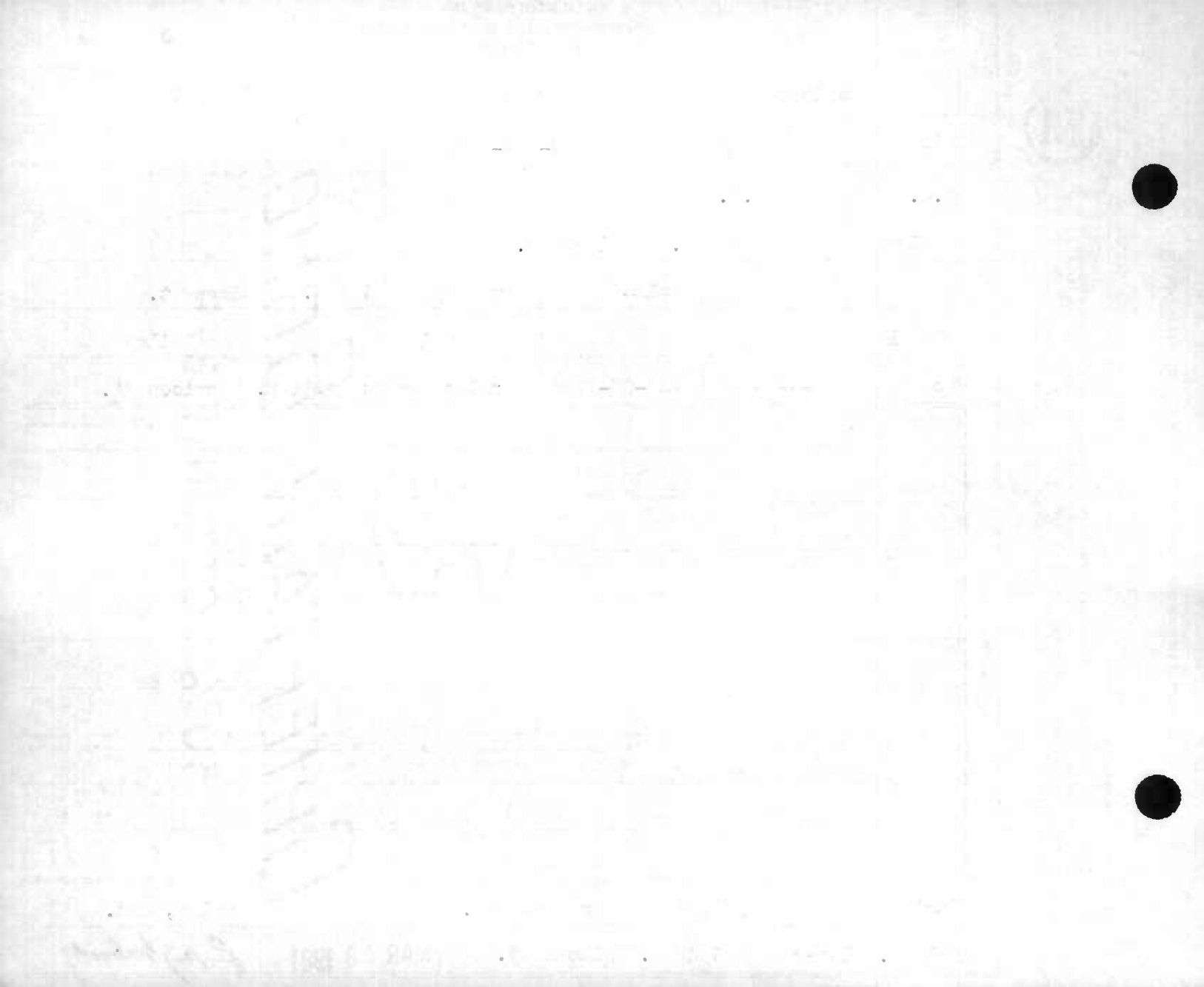


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8106954 |  |
|--|--|--|--|---|--|--|--|---|--|------------------|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Solomon Forbes</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3/22/81</b>   |  | 2b. HOUR<br><b>M</b>  |  |                  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negroid</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9-6-12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                                      |  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>124 N. Dennison St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>124 N. Dennison St.</b>   |  |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jessie</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Fannie Bailey</b>  |  |  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>245-05-3708</b>   |  | 17. INFORMANT<br><b>Bernice Forbes</b>  |  | ADDRESS<br><b>124 N. Dennison St.</b>  |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC Arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diathermic coronary heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>gum</b>  |  |  |  |   |  |  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>COPD</b>  |  |  |  |   |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> 19 <b>76</b> to <b>3/22</b> 19 <b>81</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>3/3</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |                  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3/24/81</b>   |  |   |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAACKINOFF, ARBUTHNOT</b>  |  | 22e. ADDRESS<br><b>1940 W. Balto St Balto Md 21223</b>   |  |   |  |  |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/26/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto, Md.</b>                                 |  |   |  |                  |  |
| 24. FUNERAL DIRECTOR<br><b>Donald E. Glover</b>  |  | 1348 N. Calhoun St.  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |                  |  |



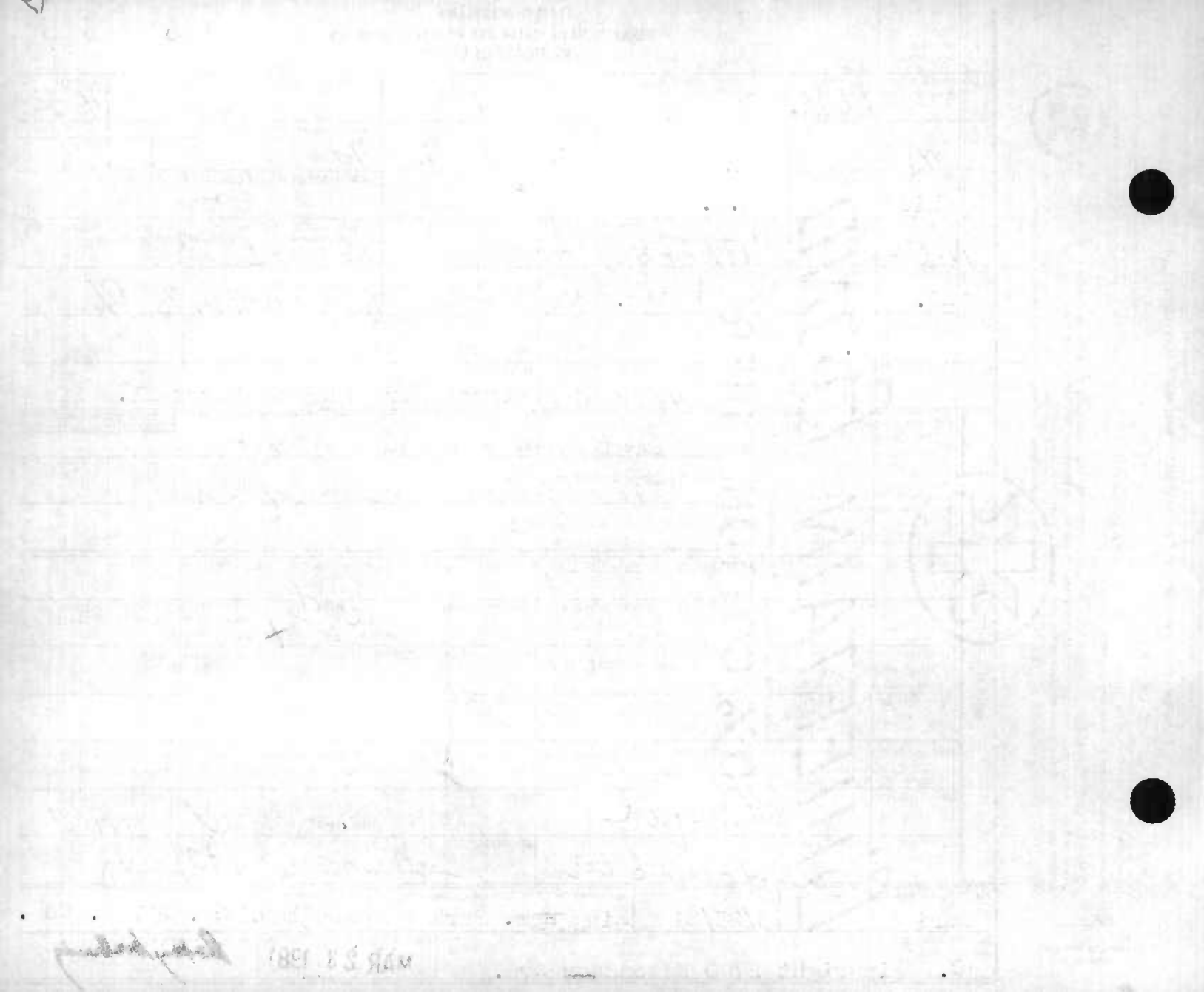


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 3 1 0 6 9 5 5   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>Wilbert Ford  |  |   |  | MONTH DAY YEAR HOUR<br>3-19-81 4:25 PM  |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>N  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 18 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>N.C.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. STREET ADDRESS   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto. City  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vander Ford  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Nash   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>248-28-7801   |  | 17. INFORMANT ADDRESS<br>Corene Ford 1225 Oakhurst Pl. Wife  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>P/a diffuse encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>MI</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sew the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>S. Suwanagool  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/19/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. SUWANAGOOOL  |  |   |  | 22e. ADDRESS<br>Lutheran Hospital MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/23/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Md. Balto. Co.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>C. Wainwright 2700 Edmondson Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



MAR 29 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
|---|--|---------|--|---|--|-------------------|--|--|--|---|--|--------------------------------------|--|----------|--|--|--|--|--|
| 1. FOR REGISTRAR  |  |         |  |   |  |                   |  |  |  | 06956   |  |                                      |  |          |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         |  |   |  |                   |  |  |  | 2b. DATE KNOWN OF DEATH   |  |                                      |  |          |  |  |  |  |  |
| JEFFREY M. FOREMAN  |  |         |  |   |  |                   |  |  |  | <input checked="" type="checkbox"/> MONTH DAY YEAR<br><input type="checkbox"/> 3 9 1981 |  |                                      |  |          |  |  |  |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD             |  | 2d. HOUR |  |  |  |  |  |
| male  |  | white   |  | 11 24 52  |  | 28 YRS.           |  | MONTHS DAYS  |  | HOURS MIN   |  | 3 9 1981                             |  | 1:30 a M |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |          |  |  |  |  |  |
| PA.   |  |         |  | USA   |  |                   |  |  |  |   |  | Baltimore City MD                    |  |          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |          |  |  |  |  |  |
| Baltimore   |  |         |  | University Hospital   |  |                   |  | Drill Press Operator   |  |   |  | Mfg.                                 |  |          |  |  |  |  |  |
| 13a. STATE  |  |         |  |   |  |                   |  |  |  | 13b. INSIDE CITY LIMITS?  |  |                                      |  |          |  |  |  |  |  |
| PA.   |  |         |  |   |  |                   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |                                      |  |          |  |  |  |  |  |
| 13c. CITY OR TOWN   |  |         |  |   |  |                   |  |  |  | 13d. STREET ADDRESS   |  |                                      |  |          |  |  |  |  |  |
| FRANKLIN  |  |         |  |   |  |                   |  |  |  | 319 Lincoln Way West  |  |                                      |  |          |  |  |  |  |  |
| 14. FATHER'S NAME   |  |         |  |   |  |                   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                      |  |          |  |  |  |  |  |
| ROBERT D. FOREMAN   |  |         |  |   |  |                   |  |  |  | MIRIAM FRANK  |  |                                      |  |          |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |         |  |   |  |                   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |                                      |  |          |  |  |  |  |  |
| NO  |  |         |  |   |  |                   |  |  |  | 194-42-7540   |  |                                      |  |          |  |  |  |  |  |
| 17. INFORMANT   |  |         |  |   |  |                   |  |  |  | ADDRESS   |  |                                      |  |          |  |  |  |  |  |
| Mrs. Miriam Foreman   |  |         |  |   |  |                   |  |  |  | 319 L.W.W. Chambersburg, Pa. 17201  |  |                                      |  |          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |   |  |                   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |          |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Multiple Injuries   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| (b)   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| (c)   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |  |   |  |                   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |                                      |  |          |  |  |  |  |  |
|   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| 20. AUTOPSY?  |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |   |  |                   |  |  |  | 21b. TIME OF INJURY   |  |                                      |  |          |  |  |  |  |  |
|   |  |         |  |   |  |                   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                      |  |          |  |  |  |  |  |
|   |  |         |  |   |  |                   |  |  |  | 12:10xx 2-28- 19 81   |  |                                      |  |          |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |  |   |  |                   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                             |  |                                      |  |          |  |  |  |  |  |
|   |  |         |  |   |  |                   |  |  |  | road  |  |                                      |  |          |  |  |  |  |  |
| 21f. LOCATION   |  |         |  |   |  |                   |  |  |  | 21g. LOCATION   |  |                                      |  |          |  |  |  |  |  |
| Penn. Rt. 316, Chamberburg  |  |         |  |   |  |                   |  |  |  | Penn.   |  |                                      |  |          |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                              |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |         |  |   |  |                   |  |  |  | TITLE (SPECIFY)   |  |                                      |  |          |  |  |  |  |  |
| Ann M. Dixon, M.D.  |  |         |  |   |  |                   |  |  |  | M.D. Assistant MEDICAL EXAMINER   |  |                                      |  |          |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |   |  |                   |  |  |  | DATE SIGNED   |  |                                      |  |          |  |  |  |  |  |
|   |  |         |  |   |  |                   |  |  |  | 3-9-81  |  |                                      |  |          |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |   |  |                   |  |  |  | 23b. DATE   |  |                                      |  |          |  |  |  |  |  |
| BURIAL  |  |         |  |   |  |                   |  |  |  | MARCH 11, 1981  |  |                                      |  |          |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |         |  |   |  |                   |  |  |  | 23d. LOCATION   |  |                                      |  |          |  |  |  |  |  |
| PARKLAWN MEMORIAL GARDENS   |  |         |  |   |  |                   |  |  |  | GREENE TWP. FRANKLIN CO. PA.  |  |                                      |  |          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |   |  |                   |  |  |  | DATE REC'D BY REGISTRAR   |  |                                      |  |          |  |  |  |  |  |
| Eline Funeral Home  |  |         |  |   |  |                   |  |  |  | MAR 13 1981   |  |                                      |  |          |  |  |  |  |  |
| NAME  |  |         |  |   |  |                   |  |  |  | REGISTRAR'S SIGNATURE   |  |                                      |  |          |  |  |  |  |  |
| Reisterstown, Md. 21136   |  |         |  |   |  |                   |  |  |  |   |  |                                      |  |          |  |  |  |  |  |

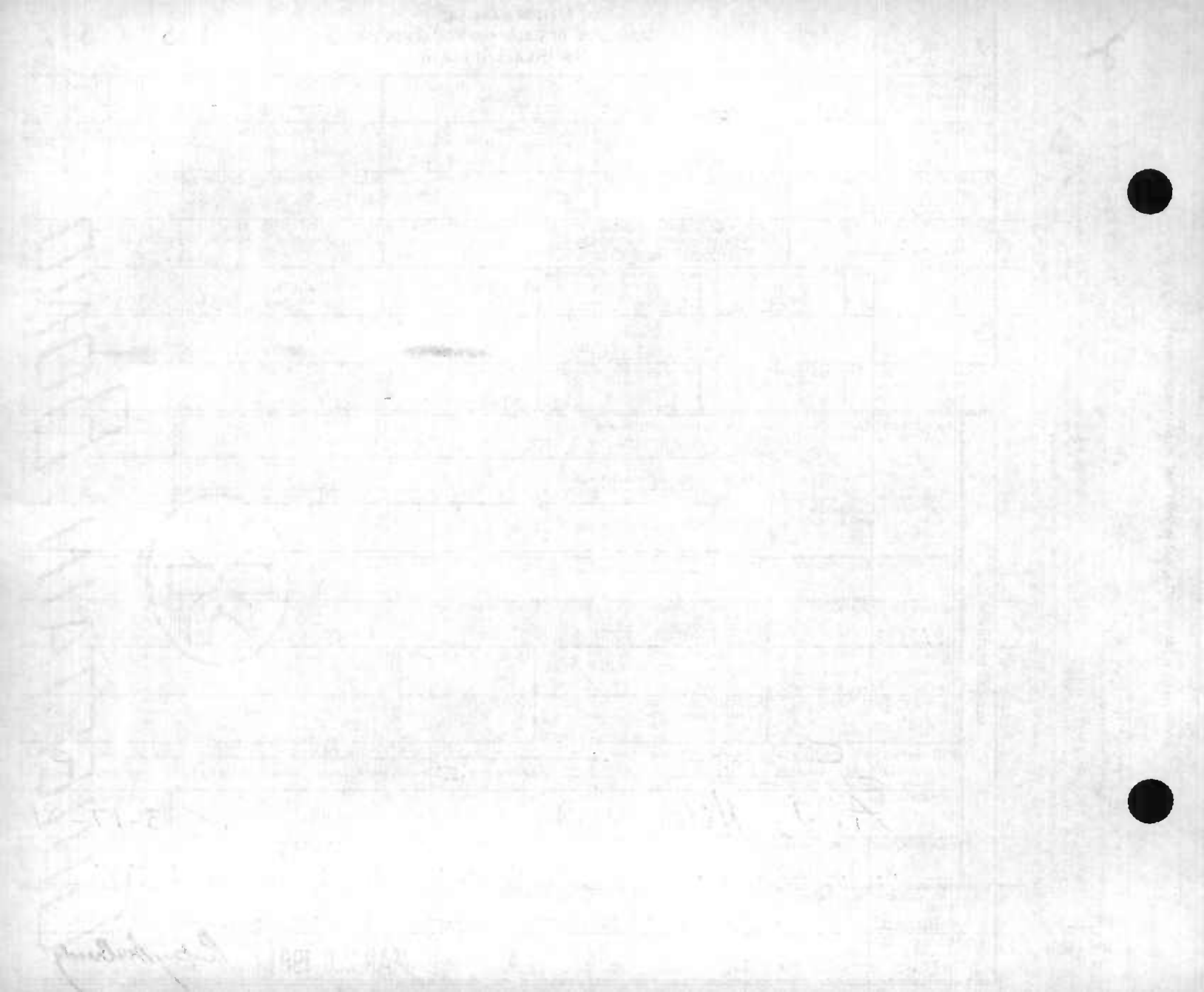


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 9 5 7  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| ELLA Nora FORNWALT   |  |  |  | MARCH 17, 1981 6:34 P.M.   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE   |  |
| Female   |  | White  |  | 9 MONTH 4 YEAR 1894  |  | 86 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Church Hospital Inc.   |  | Housewife  |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  |  |  | Baltimore  |  | Jones Creek  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| John   |  |  |  | Elizabeth  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| No   |  |  |  | 213/52/2911  |  | Eleanor M. Rehak same as 13e.                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) GANGRENE OF LEFT LEG - TWO MONTHS  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 2/2/81   |  | GANGRENE LEFT LEG  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |  |  |
|  |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 24, 19 81, to MARCH 17, 19 81, that (I) (we) lost saw the deceased alive on MARCH 17, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| A. J. Helou, M.D.  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 3-17-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| A. J. HELOU, M.D.  |  |  |  | CHURCH HOSPITAL<br>100 N. BROADWAY, BALTIMORE, MD 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| Burial   |  | 3/21/1981  |  | Oak Lawn Cemetery  |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Walter Brooks Bradley Inc. Balto., Md.   |  |  |  | MAR 20 1981  |  | [Signature]  |  |



#5,6, Film G553 3/26/81 kam

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 5 8

REG. NO.

|   |  |  |  |   |                                       |   |
|---|--|--|--|---|---------------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LEONA H. FORWOOD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-8-81</b>               |   | 2b. HOUR<br><b>2:00AM</b>             |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 30, 1896</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home Hospital</b>             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Shoe</b>           |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                    |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herman Helmig</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Fuchs</b> |   |                                       |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218 03 9175</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>W.G. Forwood Same</b>  |                                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4442</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST, GANGRENE WITH LOWER EXTREMITIES</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL EMBOLI FEMERAL, ATRIAL FIBRILLATION, HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEART FAILURE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                                       |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CONGESTIVE HEART FAILURE, RENAL FAILURE</b>  |  |  |  |   |                                       |   |
| 19a. DATE OF OPERATION<br><b>3-2-81</b><br><b>3-5-81</b>  |  | 19b. COMPLICATIONS<br><b>EMBOLECTOMY, AMPUTATION, LOWER EXTRIMITIES</b>  |  | 19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>         |                                       |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3-1 81 3-8 81</b>   |                                       |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-8 81</b> to <b>3-8 81</b> , that (I) (we) last saw the deceased alive on <b>3-8 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.  |  |  |  |   |                                       |   |
| 22b. SIGNATURE<br><b>Sompalli Davd</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-8-81</b>   |                                       |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SOMPALLI, MD.</b>   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b><br><b>100 N. BROADWAY BALTIMORE, MD. 21231</b>  |  |   |                                       |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11 March 81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |                                       |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burke Funeral Home 21211</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1981</b>  |                                       |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Henry McBrady</b>  |  |  |  |   |                                       |   |



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF OF BUREAU  
WASHINGTON, D. C.

REPORT OF THE CHIEF OF BUREAU  
FOR THE YEAR 1911

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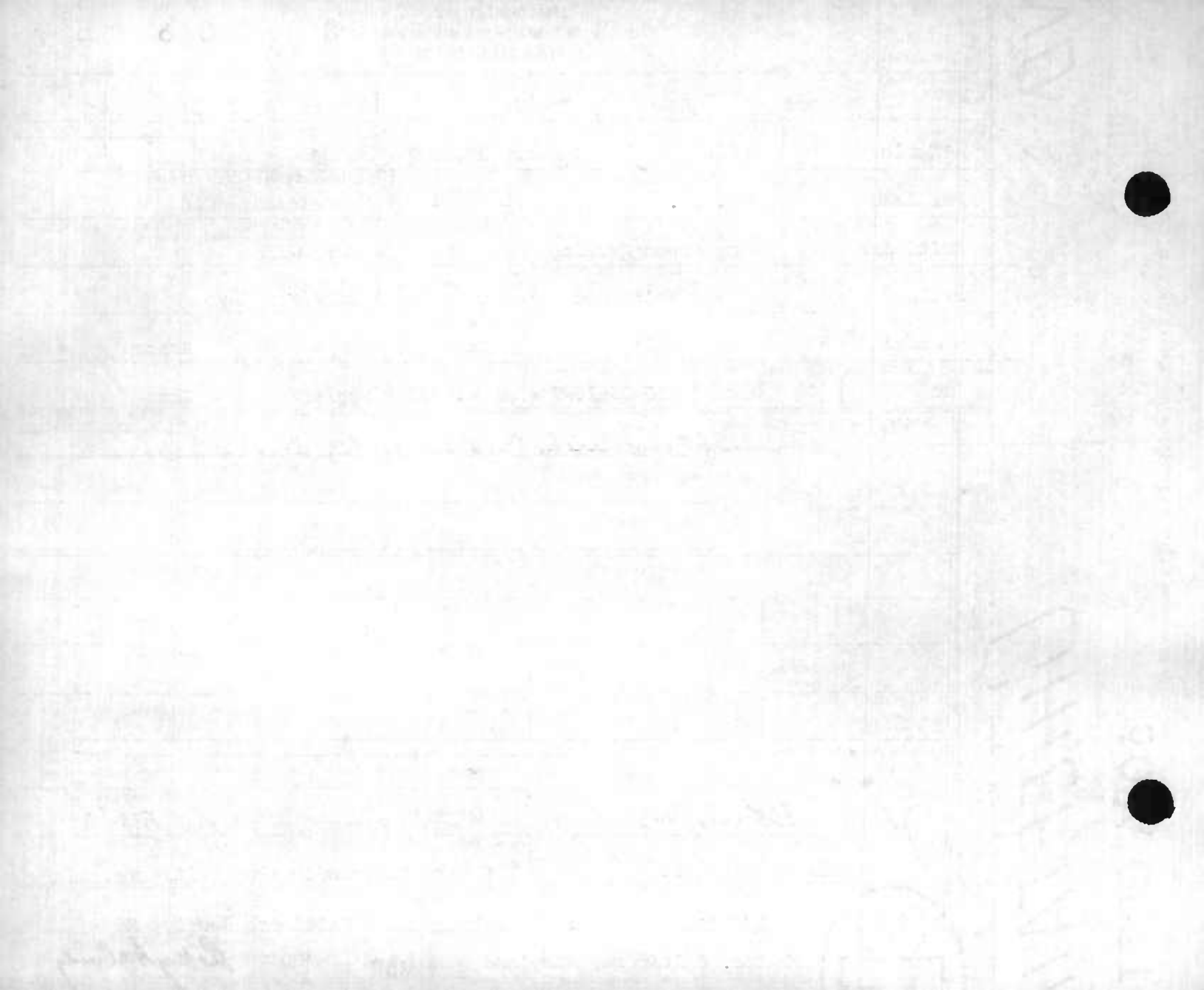


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |                                |  |   |  |
|--|--|--|--|---|--|---|--------------------------------|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8106959   |  |   |  |   |                                |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Grace A Fowble  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 1, 1981           |   |                                | 2b. HOUR<br>M  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 18, 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                     |                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |                                | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cravin Cole  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Etta M Bossom |   |                                |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-05-1697   |  | 17. INFORMANT<br>Mr W. Ralph Regler   |  |   | ADDRESS<br>Same                |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |   |  |   |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (we) last saw the deceased alive on _____, 19_____, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)  |  |  |  |   |  |   |                                |  |   |  |
| 22b. SIGNATURE<br>John W. Bowie MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |                                | 22c. DATE SIGNED<br>3/2/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John W Bowie, D.  |  |  |  | 22e. ADDRESS<br>500 West University Pkwy Baltimore, Md  |  |   |                                |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/4/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Black Rock  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Butler Baltimore County Md      |                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela M. Brady                                |                                |  |   |  |



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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8106960  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) <u>Etta M Fox</u>  |  |   |  | MONTH DAY YEAR 3 16 81  |  |   |  |
| 3. SEX <u>F</u>  |  |   |  | 2b. HOUR 4 <sup>04</sup> P.M.   |  |   |  |
| 4. RACE <u>Cauc</u>  |  |   |  | 5. DATE OF BIRTH  |  |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <u>26</u> YRS  |  |   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Indiana</u>   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>US</u>  |  |   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt. City</u> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Balt. City</u>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>RRP University Hosp</u>                 |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE <u>PENNA</u> 13b. COUNTY <u>Lancaster</u>   |  |   |  | 13c. CITY OR TOWN <u>New Holland</u>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>JUNAS R. ZIMMERMAN</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>WILMA S MARTIN</u>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>  |  |   |  | 16b. SOCIAL SECURITY NO. <u>315-64-4367</u>   |  |   |  |
| 17. INFORMANT ADDRESS <u>Samuel L. Fox R.D.#1 New Holland, Pa.</u>   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>fungal septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hodgkin's disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>81</u> , to <u>3/16</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>81</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.         |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>Elizabeth Poplin</u> MD  |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <u>3/16/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elizabeth Poplin MD</u>   |  |   |  | 22e. ADDRESS <u>22 S. Greene St. Balt. MD.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>New Holland Mennon Earle Twp. Lancaster Pa.</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME <u>Wm. E. Johnson</u>  |  | ADDRESS <u>8521 Loch Raven Blvd.</u>                                |  | 25a. DATE REC'D. BY REGISTRAR <u>MAR 23 1981</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Robert H. Brady</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8106961  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>CHARLES C. FRAHM, SR.  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 23 81   |  |  |  | 2b. HOUR<br>3:40 P.M.   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6 23 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>82   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Missouri  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>25 Oaklee Village |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tool & Die Maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>25 Oaklee Village Balto., Md.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Frahm   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>UNKNOWN   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO<br>WW I   |  | 17. INFORMANT<br>Lillian H. Frahm   |  | ADDRESS Balto., Md.<br>25 Oaklee Village 21229   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Benign Prostatic Hyperplasia</u><br>1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>with Metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET  |  | CITY OR TOWN   |  | COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <u>Elmo Gayoso</u>  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/24/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elmo Gayoso   |  |   |  | 22e. ADDRESS<br>5411 Old Frederick Road Suite 8   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>3/26/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Natl. Cem   |  | 23d. LOCATION CITY OR TOWN<br>Baltimore  |  | COUNTY STATE<br>Maryland  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc.  |  |   |  | BALTO., Md. 21229<br>4107 Wilkens Ave.  |  | 25. DATE REC'D BY REGISTRAR<br>MAR 24 1981   |  | 25b. REGISTERED SIGNATURE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julia Ann Franklin</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/20/81</b>                               |  | 2b. HOUR<br><b>9 A.M.</b>                                |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cauc.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6/25/06</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5 N. Potomac St.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Operator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Cp</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Simmons</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Joyce</b>              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-3593-D</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>George Franklin, 5 N. Potomac St.</b>                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Cancer of Colon</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/20</b> , 19 <b>81</b> , to <b>3/20</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>Approx 2/1</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Morton C. Orman</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>3/20/81</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORTON C. ORMAN</b>   |  | 22e. ADDRESS<br><b>2936 E. BALTIMORE ST 21224</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-23-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                             |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  | 23e. DATE OF REGISTRATION<br><b>MAR 24 1981</b>   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Fun.Home, 3331 Brehms Lane</b>   |  | 25a. DATE OF REGISTRATION<br><b>MAR 24 1981</b>   |   |  |  |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 9 6 3   |  |  |  |
|--|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Rita Frazer</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28, 1981</b>  |  | 2b. HOUR<br><b>6:40p</b> M   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 25, 1935</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>45</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS RUSSO</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA LEVIN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS<br><b>MR. CHARLES FRAZER 4261 LABYRINTH RD. (21215)</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749 Metastatic Adenocarcinoma of the breast</b><br>IMMEDIATE CAUSE (a) <b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 23, 1981</b> , to <b>March 28, 1981</b> , that <del>XX</del> (we) lost saw the deceased alive on <b>March 28, 1981</b> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) did <del>not</del> view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Harry E. Nervino, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/28/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harry E. Nervino, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAR. 29, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KOVNA CONG. CEM</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE, MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS</b>   |  |   |  | 6010 REISTERSTOWN RD.<br>BALTIMORE, MD. (21215)   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1981</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Phyllis H. H. H.</b>  |  |   |  |   |  |  |  |



Picture Maryland General Hospital

Baltimore City

March 28, 1971

Tracer

Hits

8:40a

Metastatic Adenocarcinoma of the Breast

xx March 28, 1971  
xx March 28, 1971  
xx March 28, 1971

Harry E. Harvino, M.D.  
c/o 627 Linden Ave. Baltor. MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |                   |
|--|--|---|-------------------|
| 1. FOR STATE REGISTRAR   |  | 06964   |                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE KNOWN OF DEATH   |                   |
| FIRST MIDDLE LAST<br><b>ELSIE FRAZIER</b>  |  | MONTH DAY YEAR<br><b>3-18 19 81</b>   |                   |
| 3. SEX   | 4. RACE                                    | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) |
| <b>female</b>  | <b>black</b>                               | MONTH DAY YEAR<br><b>78 YRS.</b>  | LAST BIRTHDAY     |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7c. DATE PRONOUNCED DEAD  |                   |
| <b>Md.</b>   |  | MONTH DAY YEAR<br><b>3-18 19 81</b>   |                   |
| 7d. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |
| <b>USA</b>   |  | <b>Baltimore City</b>   |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  |                   |
| <b>Baltimore</b>   |  | <b>Sinai Hospital</b>   |                   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                   |
|  |  |   |                   |
| 13a. STATE   |  | 13b. COUNTY   |                   |
| <b>Md.</b>   |  | <b>Balto.</b>   |                   |
| 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS   |                   |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | <b>4307 Groveland Ave.</b>  |                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |                   |
| FIRST MIDDLE LAST<br><b>Frank Wheatley</b>   | FIRST MIDDLE LAST<br><b>Alice Robinson</b> |   |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |                   |
| <b>No</b>  |  | <b>213-64-1230</b>  |                   |
| 17. INFORMANT  |  | ADDRESS   |                   |
|  |  |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                   |
| PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |                   |
| (b)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |                   |
| (c)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |
|  |  |   |                   |
| 20. HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |                   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |  |   |                   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                   |
| 22a. I certify that I took charge of the remains described above, held on (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |                   |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)   |                   |
| <b>Margaret A. Korell, M.D.</b>  |  | <b>Assistant</b>  |                   |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | DATE SIGNED   |                   |
| <b>Margaret A. Korell, M.D.</b>  |  | <b>3-19-81</b>  |                   |
| ADDRESS  |  |   |                   |
| <b>111 Penn Street</b>   |  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |                   |
| <b>Removal</b>   |  | <b>4/1/81</b>   |                   |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |                   |
|  |  |   |                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25. DATE REC'D. BY REGISTRAR  |                   |
| <b>Anatomy Board Balto., Md.</b>   |  | <b>APR 10 1981</b>  |                   |
|  |  | 25b. REGISTRAR'S SIGNATURE  |                   |
|  |  | <b>Anthony McCreedy</b>   |                   |

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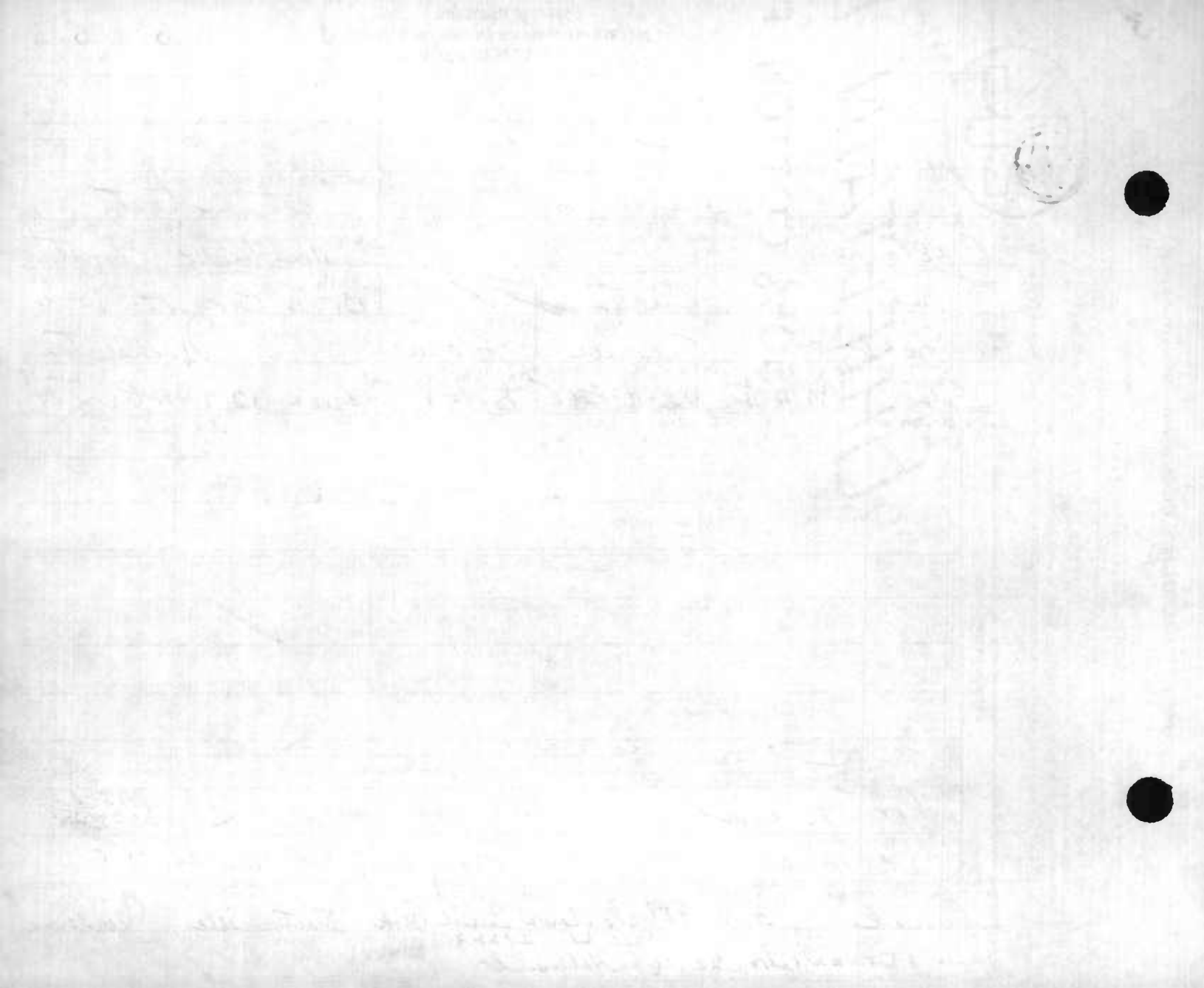
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 9 6 5   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR HOUR   |  |  |  |
| GLEN E. FRAZIER  |  |  |  | 3 25 81 6 <sup>30</sup> PM  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| male   |  | White  |  | MONTH DAY YEAR<br>4 29 13   |  | 67 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| N. CAROLINA  |  | U.S.A.   |  |   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | MERCY Hosp   |  | Furniture Trader  |  | Furniture  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE CITY COUNTY   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. Md. Baltimore   |  |  |  |   |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13c. STREET ADDRESS   |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | 1217 W. Cross St. 21230   |  |  |  |
| John S. Frazier  |  | Bora   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS   |  |  |  |
| Yes  |  | 226-10-8265  |  | Mary V. Frazier 1217 W. Cross St. 21230   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 CARDIOGENIC SHOCK  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE M.I.'S   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-25-81, 19, to 3-25-81, 19, that (I) (we) last saw the deceased alive on 3-25-81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |
| John T. Lapinsky   |  | MD   |  |   |  | 3-25-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |  |  |
| LAPINSKY   |  | Mary Hospital Baltimore  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (CITY OR TOWN) COUNTY STATE                      |  |
| Burial   |  | 3-28-1981  |  | Opelikon Burial Park  |  | Martinsville, Virginia   |  |
| 24. FUNERAL DIRECTOR   |  | 25. DATE REC'D. BY REGISTRAR   |  | 26. REGISTRAR'S SIGNATURE   |  |  |  |
| John J. Cowan & Son, Inc. 901 Hollins St.  |  | MAR 30 1981  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 1 0 6 9 6 8   |  |
|---|--|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Samuel A Freedman   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 21, 1981  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6-27-23  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 8. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.  |  | 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LADIES CLOTHES  |  | 13. STREET ADDRESS<br>5610 CROSS COUNTRY BLVD.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MEYER SAUL FREEDMAN  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ROSE SHARIRA SCHAPIRA  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES WW II ARMY                                       |  |
| 17. INFORMANT ADDRESS<br>MRS. SYLVIA FREEDMAN 5610 CROSS COUNTRY BLVD   |  | 18. SOCIAL SECURITY NO.<br>216-12-8884   |  | 19. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u><br>1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Respiratory insufficiency</u><br>(c) <u>Metastatic Lung lesions from Bladder Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus, chronic anemia</u>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that this hospital attended the deceased from <u>March 12</u> , 19 <u>81</u> , to <u>March 21</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>March 21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>D.A. Kleinerman</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3/21/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.A. Kleinerman, MD  |  | 22e. ADDRESS<br>Sinai Hospital   |  | 22f. ADDRESS<br>Belvedere @ Greenspring<br>Baltimore, MD 21215  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE CREV)<br>BURIAL   |  | 23b. DATE<br>3/22/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>AITZ CHAIM CEM.   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Robert A. Brady</u>  |  | 25c. REGISTRAR'S SIGNATURE   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

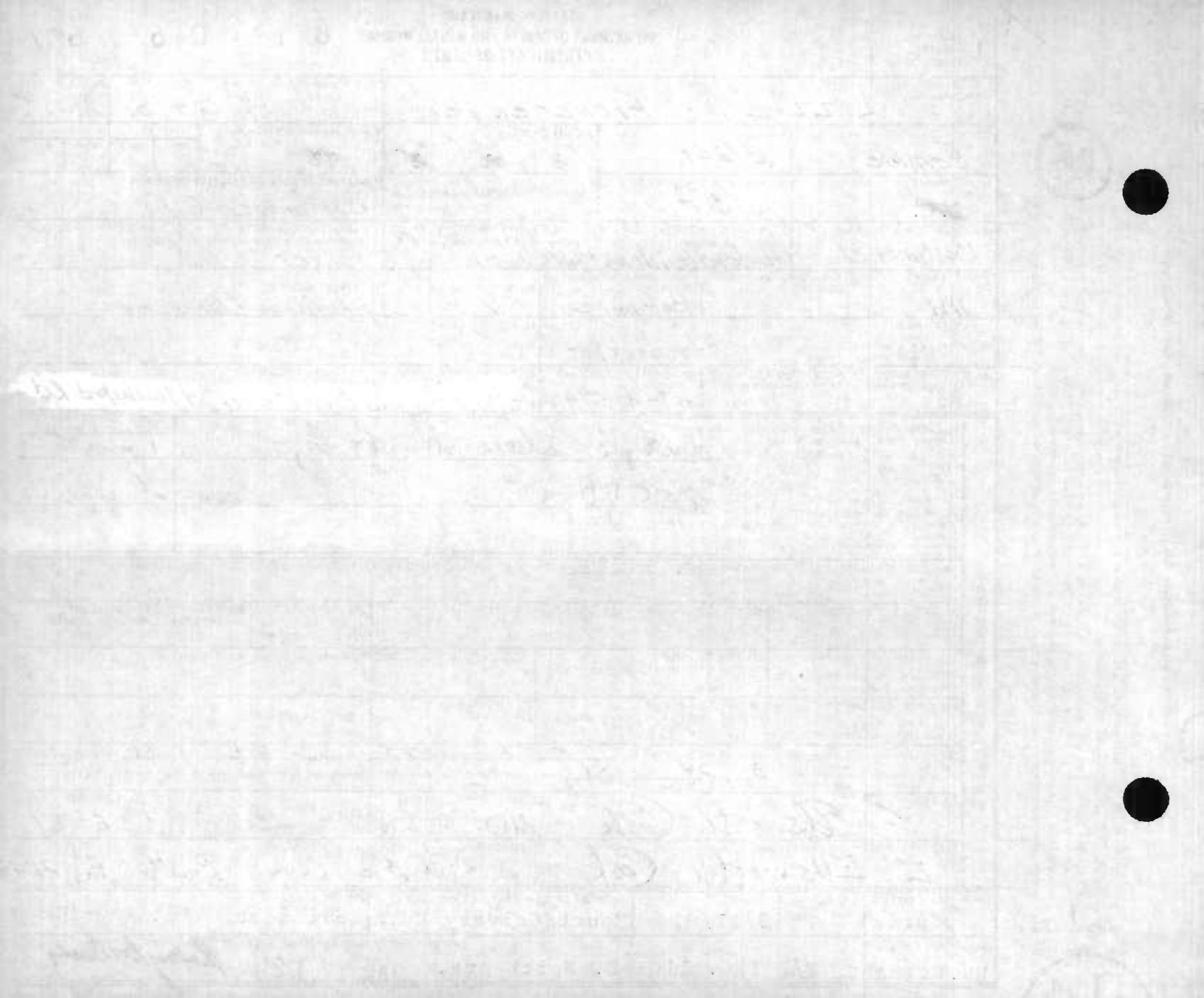
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 06967

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |   |   |   |  |
|--|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lizzie M. Froneberger</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3 24 81</b> |   |   | 2b. HOUR <b>2:20</b> M  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Black</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 1 03</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.                    |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.    |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Gardens Conv. Center</b> |   | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Packer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |  |
| 13a. STATE <b>MD</b>   |  |  | 13b. COUNTY                                     |   | 13c. CITY OR TOWN <b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Froneberger</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST      |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>217-10-7141</b>     |   | 17. DECEASED'S ADDRESS <b>Russell Walker 3216 Woodland Avenue</b>                 |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>multiple ulcers rt + left legs</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>several years</b>  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8 2 19 78</b> , to <b>3 24 19 81</b> , that (I) (we) last saw the deceased alive on <b>3 24 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE <b>E. Ellsworth Cook</b> MD   |  |  |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>3 26 81</b>                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook</b>   |  |  |   | 22e. ADDRESS <b>2431 Md. Ave. Balto. Md 21218</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/27/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary Cem.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD.</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>WM.C. MARCH F/H INC.</b> ADDRESS <b>1101 E. North Ave.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 27 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>                 |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |                      |   |  |   |  |   |  | 8 1 0 6 9 6 8  |          |  |
|---|--|--|----------------------|---|--|---|--|---|--|--|----------|--|
| 1- FOR STATE REGISTRAR  |  |  | CERTIFICATE OF DEATH |   |  |   |  |   |  |  | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LUCINDA JANE FRY</b>   |  |  |                      |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 18 81</b>                             |  |   |  | 2b. HOUR<br><b>12:35 P M</b>   |          |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 27, 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS.   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |  |   |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KESWICK NURSING HOME</b> |                      |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                      |  |  |          |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |                      |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |          |  |
| 13a. STREET ADDRESS<br><b>3614 Sussex Road</b>  |  |  |                      |   |  |   |  |   |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Stocksdate</b>   |  |  |                      |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Holtz</b>                |  |   |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |                      | 16b. SOCIAL SECURITY NO.<br><b>213-09-7488 D</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>James H. Fry Same as #13.</b>                          |  |   |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>9 yrs.</b>  |  |  |                      |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Parkinson's Disease</b>   |  |  |                      |   |  |   |  |   |  |  |          |  |
| 19a. DATE OF OPERATION  |  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |   |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>28 June 19 72</b> to <b>18 Mar 81</b> , that (I) (we) lost saw the deceased alive on <b>18 Mar 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |                      |   |  |   |  |   |  |  |          |  |
| 22b. SIGNATURE<br><b>Aubrey Richardson</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |                      |   |  | 22c. DATE SIGNED<br><b>18 MAR 1981</b>  |  |   |  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Aubrey Richardson, M.D.</b>   |  |  |                      |   |  | 22e. ADDRESS<br><b>Keswick Home Baltimore, Maryland</b>                               |  |   |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |                      | 23b. DATE<br><b>Mar. 20, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |                      |   |  | ADDRESS<br><b>1050 York Road Towson, Md. 21204</b>                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>                       |  |  |          |  |
|   |  |  |                      |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Aubrey Richardson</b>                                |  |   |  |  |          |  |

132029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR  |  |   |  |
| Anthony S Fulco   |  |  |  | 3/29/81 6:45 AM   |  |   |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS.   |  |
| M   |  | White  |  | 08 24 35  |  | 45  |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| Maryland  |  | USA  |  | Baltimore City MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                       |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore City  |  | U. of Maryland Hosp.   |  | Unemployed  |  |   |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS   |  |   |  |
| Maryland  |  | Baltimore  |  | 7921 Dalesford Rd.  |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |
| Joseph Fulco  |  |  |  | Antoinetta Constantino  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
|   |  |  |  | 218-32-8304   |  | Donis J. Fulco - 7921 Dalesford Rd.-21234   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2051  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Blast Crisis - Chronic Granulocytic Leukemia   |  |  |  |   |  | 6 days  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  | 10 mos.   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 80 to March 19 81, that (I) (we) last saw the deceased alive on March 29 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  | 22c. DATE SIGNED 3-29-81  |  |
| 22b. SIGNATURE D. HOGGE   |  |  |  | DEGREE MD   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. HOGGE  |  |  |  | 22e. ADDRESS 22 S Green St. Baltimore   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 4-1-81   |  | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.                            |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.  |  |
| 24 FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR MAR 31 1981   |  | 25b. REGISTRAR'S SIGNATURE  |  |



Continued

Director

John P. Fulton - 7251 Wilkesford Rd. - 21304

- -

John P. Fulton

Director

4-1-71

Initial

John P. Fulton - 7251 Wilkesford Rd. - 21304

MAR 31 1971

*[Handwritten signature]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |  | REG. NO. 8106970   |  |   |  |
|---|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |   |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ESTHER GAITHER</b>  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-28-81</b>  |  | 2b. HOUR <b>920 P.M.</b>  |  |
| 3. SEX <b>F</b>   | 4. RACE <b>BLACK</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>02 28 05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP.</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>Balto.</b>   |   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3800 W. BELVEDERE AVE.</b> 21215   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachael Keith</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO. <b>N/A</b>  |  | 17. INFORMANT ADDRESS <b>Mariam Hicks 4529 Homer Avenue</b>                                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>4120<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b><br>Approximate interval between onset and death: <b>1/2 hr.</b><br>at least 1 yr. |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hx of MI, RENAL FAILURE, &amp; DIABETES MELLITUS</b>   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> 19 <b>81</b> , to <b>3/28</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.                                       |   |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Michael R. Kessler</b> DEGREE   |   |  |  | 22c. DATE SIGNED <b>3/28/81</b>  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL R. KESSLER M.D.</b>  |   |  |  | 22f. ADDRESS <b>SINAI HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |   | 23b. DATE <b>4/2/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>                                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 30 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |



(14)



MAR 20 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8106971  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE GALLAHER LAST  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 07 1981  |   |   | 2b. HOUR<br>12 P M   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>08 04 03   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(IF NOT OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY 13c. CITY OR TOWN BALTIMORE  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>3331 Abell Ave   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>KING MAW  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNA MALLBERRY   |  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO.<br>22503 6384   |  | 17. INFORMANT ADDRESS<br>Helen Gallagher 3331 Abell Ave   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.     |  |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 days             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Cerebral vascular accident, congestive heart failure  |  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPT? YES <input type="checkbox"/> NO <input type="checkbox"/>                           |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 07, 19 81, to March 07, 19 81, that (I) (we) lost saw the deceased alive on March 07, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br>Richard Lebow  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   | 22c. DATE SIGNED<br>03-07-81  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD Lebow   |  |  |  | 22e. ADDRESS<br>Union Memorial  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>CREMATION   |  | 23b. DATE<br>3/10/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sherwood Mem Park   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Salem VA.                            |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>John J. Coach   |  |  |  | ADDRESS<br>1211 Chesapeake Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981                                    |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                          |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |   |  |   |  | REG. NO. 06972  |  |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Martha J. Gamble   |  |                  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>3 9 19 81 |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 1 1920  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>61  |  | 7. IF UNDER 1 YR. MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>3 9 19 81  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  |                  |  | 7c. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Procudtion   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Illinois Co.   |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1924 Haselmere Road  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Sherman Foltz   |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Shrader   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>235-12-0932  |  | 17. INFORMANT<br>Billy E. Gamble  |  | ADDRESS 1924 Haselmere Rd<br>Balto. MD 21222  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Blunt Injury to Trunk &amp; Head</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR<br>1:00 P.M. 3 9 19 81  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Passenger of auto/truck impact |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street  |  | 21f. LOCATION Philadelphia OR TOWN COUNTY STATE<br>Rd. & Rossville Blvd., Essex, Baltimore, Md.                 |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>  |  |                  |  | TITLE (SPECIFY) M.D. Assistant   |  |   |  | DATE SIGNED 3/10/81   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>   |  |                  |  | ADDRESS <u>111 Penn Street</u>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>3/13/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>White Marsh, Baltimore, MD   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue, Dundalk, MD 21222  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. J. Kelly</u>  |  |   |  |

1001 1 1 8AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |                                | 8   | 1                             | 0   | 6 | 9                       | 7 | 3 |
|--|--|--|--|---|--|--|--|--|--------------------------------|---|-------------------------------|---|---|-------------------------|---|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |                                | REG. NO.  |                               |   |   |                         |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mathilda Augusta Gantt</b>  |  |  |  |   |  |  |  |  |                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/9/81</b>  |                               |   |   | 2b. HOUR<br><b>5 P.</b> |   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1, 1906</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN. |   |   |                         |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |                                |   |                               |   |   |                         |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Operator</b>                              |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b>  |                               |   |   |                         |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |                                | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               | 13b. STREET ADDRESS<br><b>5001 Westland Blvd.</b> |   |                         |   |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Arbutus</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Wilkens</b>                       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Therese B. 2</b>   |                                |   |                               |   |   |                         |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>  |  | 17. INFORMANT ADDRESS<br><b>2111 Oak Lodge Rd. - Catonsville, Md.</b>   |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4960</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic obstructive lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b> |  |  |  |   |  |  |  |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21228.</b>                                   |                               |   |   |                         |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |   |                               |   |   |                         |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> , 19 <b>81</b> , to <b>3/9</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |  |   |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 22b. SIGNATURE<br><b>Jeffrey Abram</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED   |                                |   |                               |   |   |                         |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey Abrams</b>   |  | 22e. ADDRESS   |  |   |  |  |  |  |                                |   |                               |   |   |                         |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>3/12/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery - Baltimore, Maryland</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |                                |   |                               |   |   |                         |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Sterling Funeral Estate</b>   |  | ADDRESS<br><b>736 Edmondson Ave. Catonsville, Md. 21228</b>  |  | 24b. REG. NO.<br><b>MAR 12 1981</b>   |  | 24c. REGISTRAR'S SIGNATURE   |  |  |                                |   |                               |   |   |                         |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81 06974   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FRANCES GARCIA  |  |  |  | 2b. HOUR 9:38pm   |  |   |  |
| 3 SEX Female   |  | 4 RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR April 3, 1888   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 92  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Maryland  |  | 13b. COUNTY 21224  |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Dudeck  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |   |  |
| 16b. SOCIAL SECURITY NO. 213-54-1747   |  | 17. INFORMANT ADDRESS D.J. Garcia Timonium, Maryland 21093   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>4292 DUE TO, OR AS A CONSEQUENCE OF ASPIRATION PNEUMONIA<br>(b) OLD <del>CARDIOVASCULAR</del> CARDIOVASCULAR ACCIDENT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10.   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 03-26-19 81, to 03-27-19 81, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 03-27-19 81, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE (Type or Print) DR. WALKER IMPAGLIATELLI M.D.   |  |  |  | DEGREE  |  | 22c. DATE SIGNED 3/27/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. <del>XXX</del> BROADWAY BALTIMORE, MARYLAND 31  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE March 31, '81  |  | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.   |  |
| 24. FUNERAL DIRECTOR NAME William E. Johnson 8521 Loch Raven Blvd.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR MAR 30 1981   |  | 25b. REGISTRAR'S SIGNATURE  |  |



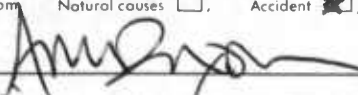

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1-  
FOR  
STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |                   |  |  |  |  |   |                 |                                |  |   |  |  |                              |  |  |  |  |
|---|--|------------------|-------------------|--|--|--|--|---|-----------------|--------------------------------|--|---|--|--|------------------------------|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>REGINALD |  |  | MIDDLE<br>GARDNER                          |  |   | LAST<br>GARDNER |                                |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>2 3 19 81   |  |  | 2b. HOUR<br>M<br>3:59<br>P M |  |  |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>negro |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 13 61  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>20 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                 | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 22 19 81  |  |  | 7d. HOUR<br>P M              |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  |                  |                   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |  |                              |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>800 blk. Lancaster St. |  |  |  |   |                 |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |                              | 12b. KIND OF BUSINESS OR INDUSTRY      |  |  |  |
| 13a. STATE<br>MD  |  |                  |                   | 13b. COUNTY<br>BALTO.  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |                 |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  |                              | 13e. STREET ADDRESS<br>Rosewood Center |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sherman Gardner   |  |                  |                   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Shirley Wilson   |                 |                                |  |   |  |  |                              |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |                   | (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>219-74-2790   |                 |                                |  | 17. INFORMANT ADDRESS<br>Shirley Gardner 243 S. Ballow Ct.  |  |  |                              |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br>9109<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |                  |                   |  |  |  |  |   |                 |                                |  |   |  |  |                              |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |                   |  |  |  |  |   |                 |                                |  |   |  |  |                              |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                 |                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |  |                              |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 2/3 ? 19 81  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject drowned.   |                 |                                |  |   |  |  |                              |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Water   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>800 Blk. Lancaster St, Balto, Md.  |                 |                                |  |   |  |  |                              |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                   |  |  |  |  |   |                 |                                |  |   |  |  |                              |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |                  |                   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |  |  |   |                 |                                |  | DATE SIGNED 3-23-81   |  |  |                              |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |                  |                   | ADDRESS<br>111 Penn St.  |  |  |  |   |                 |                                |  |   |  |  |                              |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                  |                   | 23b. DATE<br>3/27/81   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem   |                 |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD  |  |  |                              |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  |                  |                   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |                 |                                |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |                              |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 6 9 7 6   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |   |  | 2b. HOUR  |  |  |  |
| FIRST MIDDLE LAST<br><i>Wilhelmina Garey</i>  |  |   |  | MONTH DAY YEAR<br><i>3-27-81</i>  |  |   |  | 1 P. M.   |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5-21-1886</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>94</i>                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. Md.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>House in the Pines - Belair</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Home Maker</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STREET<br><i>Md.</i>   |  |   |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>4118 Kinsway - 21206</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Charles Vensch</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Louisa Spangler</i>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>215-05-52430</i>   |  | 17. INFORMANT<br><i>Mrs. Thelma A. Horodyski</i>  |  |   |  | ADDRESS<br><i>4118 Kinsway 21206</i>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 1, 1980</i> , to <i>March 27, 1981</i> , that (I) (we) last saw the deceased alive on <i>March 16, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Nursing Board</i>  |  |   |  | DEGREE<br><i>M.D.</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><i>3/28/81</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   |  | 23b. DATE<br><i>3-30-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cem.</i>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 31 1981</i>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |   |  |  |  |   |  |   |  | REG. NO. 06977                               |  |
|---|----------------------|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ezra Garrett</b>   |                      |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>24</b> YEAR <b>1981</b> |  | 2b. HOUR <b>10:07</b>   |  |  |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>27</b> YEAR <b>1964</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>18 YRS.</b> | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD <b>3 24 1981</b>   |  | 2d. HOUR <b>10:07</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lancaster Co. Va.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE <b>Md.</b>   |                      | 13b. COUNTY <b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1356 Calhoun St.</b>   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Peter</b> MIDDLE <b>Garrett</b> LAST  |                      |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mr. Ezra</b> MIDDLE <b>Garrett</b> LAST <b>4129 Fairfax Rd.</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                      |   |  | 16b. SOCIAL SECURITY NO. <b>217-01-0891</b>  |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                       |                      |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                      |   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                      |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                      |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |                      |   |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |   |  | DATE SIGNED <b>3-25-81</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |                      |   |  | ADDRESS <b>111 Penn Street</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>3/28/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Randallstown, Md.</b> COUNTY STATE                                       |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leroy O. Dyett</b> ADDRESS <b>4600 Liberty Heights Ave.</b>   |                      |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  |  | REG. NO. 8106978   |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>William R. Garrett   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>March 7 '81 7:10A. M.   |   |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 29 01  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                     |  |   |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore City  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital of Baltimore |  |  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ELECTRICIAN                     |  | 15. KIND OF BUSINESS OR INDUSTRY<br>Baltimore Transit Co.     |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3802 Yolando Rd.                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HOWARD B. GARRETT   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARGARET DIVEN   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213 10 0442   |  | 17. INFORMANT ADDRESS<br>MRS. ANN MAGALOTTI BALTO. MD.   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 Metastatic Cancer of the Colon<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 28, 1981, to March 7, 1981, that (I) (we) last saw the deceased alive on March 7, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Diana Rivera-Cestero   |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3/7/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Diana Rivera-Cestero  |  |   |  |  | 22e. ADDRESS<br>Sinai Hospital of Baltimore  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/10/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Co., Md.                                  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>P. J. H. H. H.   |   |  |

1001  
New York Photo Engraving Co., 212 1/2  
Henry W. Jenkins & Sons Co.  
Engraving & Lithography  
No. 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 7 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IVEY G. GARY   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MD 3 13 81                              |   | 2b. HOUR<br>5:45 AM   |
| 3. SEX<br>F  | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 04 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Restaurant |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>Virginia - |   |   | 13b. CITY OR TOWN<br>Richmond  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>At present: 3500 Hawkins Pt. Rd.         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>SIMMONS Gilpin   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH Johnson                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>-  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>223 403976   | 17. INFORMANT<br>ADDRESS<br>Nancy Wright 3500 Hawkins Point Rd.                |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) cardio pulmonary failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) metastatic breast CA.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

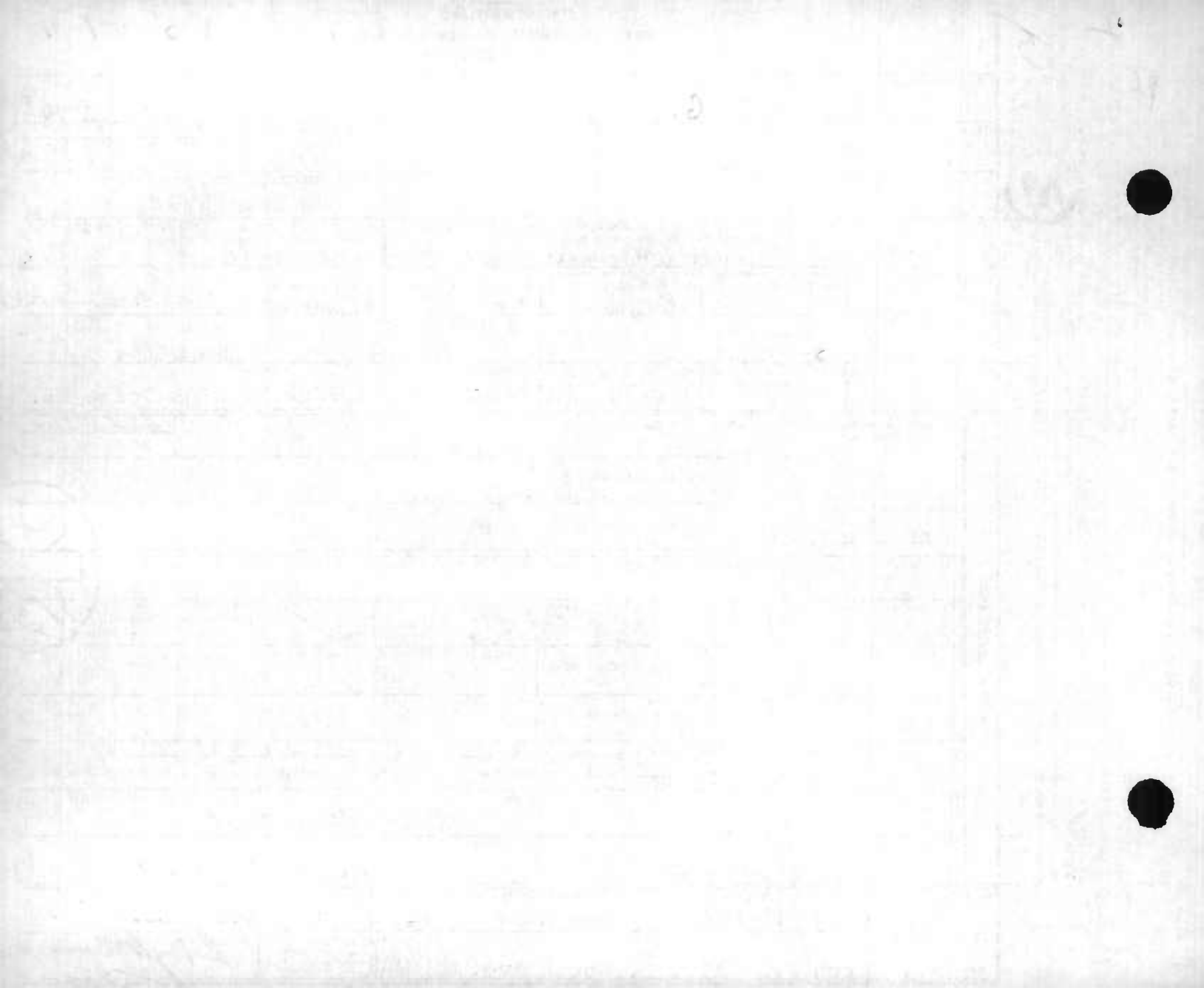
|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/2</u> 19 <u>81</u> to <u>3/13</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><u>S. Laskas</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>SUZANNE M. LASKAS</u>   |  | 22e. ADDRESS<br><u>3001 S. Hanover St. Baltimore, Md</u>   |  |  |   |

|   |                      |  |  |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial | 23b. DATE<br>3/17/81 | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H    |                      | ADDRESS<br>1101 E. North Ave.                            | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



## MEDICAL EXAMINER'S OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the medical or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified of the death within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8

06980

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | MONTH DAY YEAR  |   | 3:25 AM  |  |
| BETTY E. GAYLORD  |  | MARCH 15, 1981  |   |  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |  |
| Female  | Black  | 9 MONTH DAY YEAR  | 32 YRS.   | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Md  | U. S. A  |   | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                               |
| Baltimore   | THE JOHN'S HOPKINS HOSPITAL  |   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| Md  |  | Balto   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2126 E. Jefferson  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |  |
| James A. Gaylord  |  | Margaret E. Basey   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| No  |  | 213-54-0739   |   | James A. Gaylord 1933 Penrose Avenue   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>probable septic shock, causing</u><br><u>4589</u> DUE TO, OR AS A CONSEQUENCE OF <u>intractable hypotension -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>~ 2 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |
| <u>cerebral edema</u>   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  |
|   |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
|   |  |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 14</u> , 19 <u>81</u> , to <u>March 14</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>March 14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |  |  |
| 22b. SIGNATURE<br><u>LwMarhn</u>  |  | DEGREE  |   | 22c. DATE SIGNED<br><u>3/14/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LwMarhn</u>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |  |  |
| 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 3/19/81   |   | Westview Memorial  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   | 25a. DATE REC'D. BY REGISTRAR  |  |
| William C. March F/H 1101 E. North Ave  |  | Catonsville Md  |   | MAR 16 1981  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |  |

EV 57 451 0 7A000

100 1000



100 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

35 135 390 1 2 9 1

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 9 8 1   |  |  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
| FIRST MIDDLE LAST<br>Agnes SOPHIE Gaynor   |  |   |  | MONTH DAY YEAR<br>3-27-81   |  |  |  | 2b. HOUR<br>2:50 PM   |  |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-29-91   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO, MD City MD.                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO, MD   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOUSE WORK   |  |  |  |
| 13a. STATE<br>MD.  |  |   |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>BALTO, MD<br>6217 DANVILLE AVE 21224 MD   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK KRAL   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY SADILEK   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>218-03-0282   |  | 17. INFORMANT<br>HILDA HILKER, HAVRE DE GRACE 1075 MD                          |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Coronary heart failure</u> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/27/81</u> to <u>3/27/81</u> that (I) (we) lost saw the deceased alive on <u>3/27/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br><u>3/27/81</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KYAW NYUNT  |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>3-31-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER CEM                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>4430 BELAIR RD. BALTO, MD                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles S. Giller & Son, Inc.  |  |   |  | ADDRESS<br>901 S. CONKLING ST.<br>BALTO, 21224, MD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 30 1981                                   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | 8106982 |  |
|---|--|---|--|---|---|---|--|--|--|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |   |   |  |  |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CONRAD - GEBELEIN</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 81</b>         |   |  | 2b. HOUR<br><b>4 57 PM</b>   |  |         |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 7, 1894</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Musician</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |   |  |  |  |         |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3811 Canterbury Rd.</b>  |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Georg Gebelein</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b> |   |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-3007</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Conrad G. Gebelein 6906 Lachlan Circle</b>  |   |   |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b><br><b>4148</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Old Inferior MI</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>81</b> , to <b>3/14</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/14/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |  |         |  |
| 22b. SIGNATURE<br><b>Maria Stack</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   |   |  | 22c. DATE SIGNED   |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maria Stack</b>   |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |   |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 18, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |         |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William KEMMET Geiglein</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-13-81</b> |   |  | 2b. HOUR<br><b>4:15 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cau</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-30-18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE STREET ADDRESS)<br><b>Shock Trauma Univ.</b> |   | 12a. USUAL OCCUPATION<br><b>Fire fighter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. CITY OR TOWN<br><b>TALBOT</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>23 Westminster Rd</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM GEIGLEIN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Geiglein</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES W.W. II</b>                                       |  |  |  |
| 17. INFORMANT<br><b>Edna Geiglein</b>  |  | 18. SOCIAL SECURITY NO.<br><b>215 10 5123</b>   |   | 19. ADDRESS<br><b>21601 23 Westminster Rd. Easton Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>5728</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acidosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>liver failure, upper GI bleed, esophageal varices</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Intracerebral bleed, coagulopathy, sepsis, cirrhosis, renal failure</b> |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/7</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> , 19 <b>81</b> , to <b>5/13</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/13</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 23a. SIGNATURE<br><b>Gary M. Maulsman MD</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | DATE SIGNED<br><b>3/13/81</b>  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary M. Maulsman MD</b>  |  | 23c. ADDRESS<br><b>MTEMS</b>  |   |   |  |  |  |
| 23d. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23e. DATE<br><b>3/17/81</b>   |   | 23f. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Park</b>  |  | 23g. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonca</b>   |  | ADDRESS<br><b>4001 Ritchie Hwy Balto 21225</b>  |   | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 16 1981</b><br><b>Raymond</b>   |  |  |  |

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Items #10a-22a Film G554 4/2/81 reSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

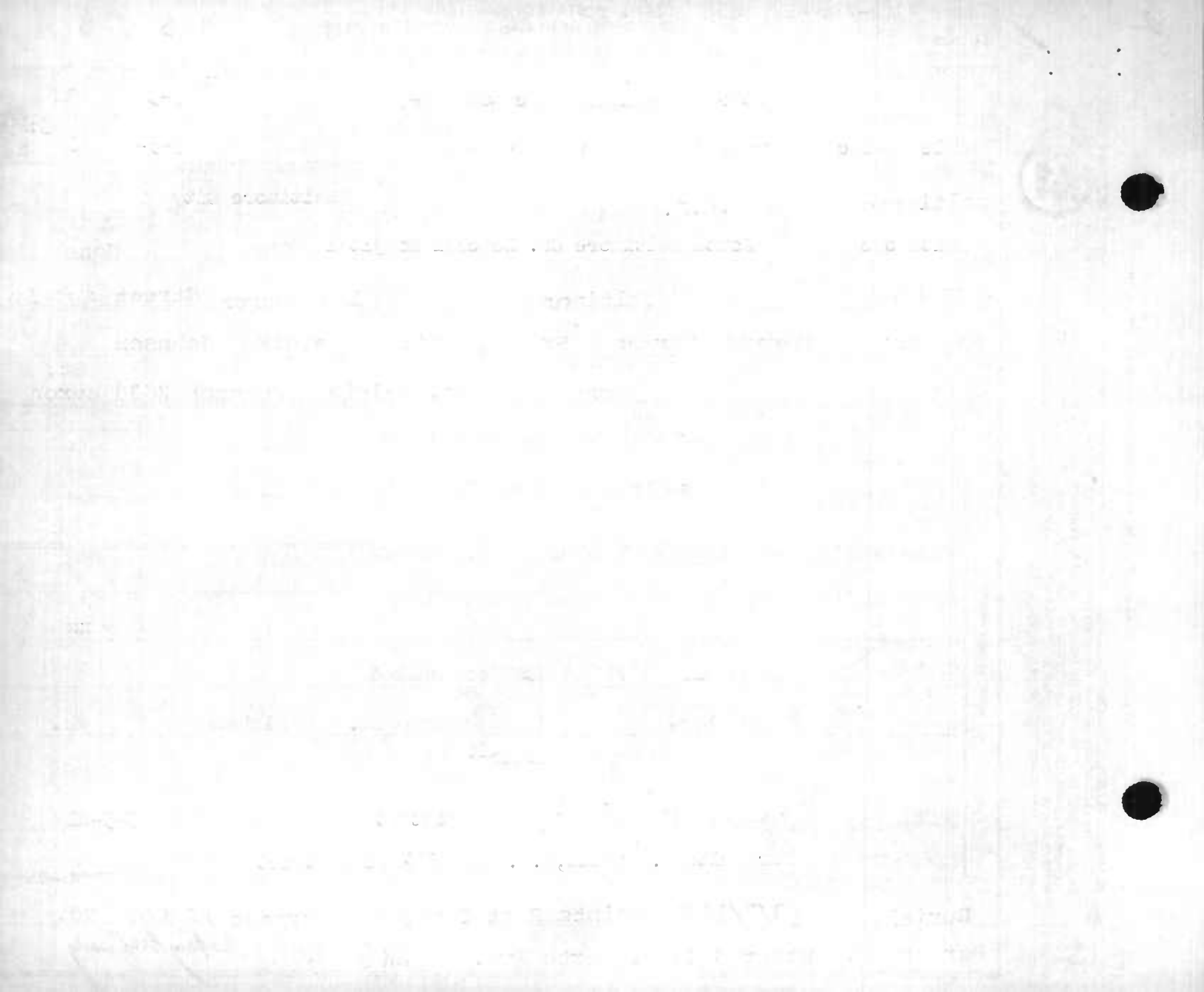
|   |                         |   |  |   |  |  |   |  |
|---|-------------------------|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anthony Gerard German Jr.</b>  |                         |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>3-5-81</b> |   |  | 2b. HOUR <b>13:10</b>  |   |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH <b>Jan.</b> DAY <b>18</b> YEAR <b>80</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>1</b> YRS.   | IF UNDER 1 YR.<br>MONTHS <b>1</b> DAYS <b>15</b>  | IF UNDER 24 HRS.<br>HOURS <b>1</b> MIN. <b>15</b>  | 2c. DATE PRONOUNCED DEAD <b>3-5-81</b>                                       |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Co. General Hospital- None</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |
| 13a. STATE<br><b>Maryland</b>   |                         |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        | 13e. STREET ADDRESS<br><b>2630 Huron Street 21230</b>                        |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Anthony</b> MIDDLE <b>Gerard</b> LAST <b>German Sr.</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>April</b> MIDDLE <b>Matoire</b> LAST <b>Johnson</b>                     |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>ADDRESS <b>St. Mrs. Sylvia Johnson-2630 Huron</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute laryngeal obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>aspiration of curdled milk</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |   |  |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:40am 3/30/81</b>                                     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject choked</b> |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>                                   |   | 21f. LOCATION<br>STREET <b>2630 Huron St.</b> CITY OR TOWN <b>Baltimore</b> COUNTY STATE <b>Md.</b>    |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .      |                         |   |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Margareta A. Korell</b>  |                         |   | M.D. <b>Assistant</b>  |   |  | MEDICAL EXAMINER<br>DATE SIGNED <b>3-5-81</b>                                |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |                         |   | ADDRESS <b>111 Penn Street</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>3/7/1981</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Saints Rest Cemetery</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN <b>Harmans</b> COUNTY <b>AA</b> STATE <b>Md.</b>      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Herbert E. Nutter-3035 W. North Ave.</b> ADDRESS  |                         |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

2543



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

OHMH - 17  
(VR A15 MAE (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
|--|---------|--|--|---|--|-----------------------------------|--|----------------------------|--|--------------------------|--|--------------------------------------|--|-------|--|------|--|----------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH    |  |                          |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR |  |          |  |
| Dorothy  |         | E.   |  | Gershon   |  | 3                                 |  |                            |  | 3                        |  | 19                                   |  | 81    |  | 4:40 |  |          |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.           |  | 7c. DATE PRONOUNCED DEAD |  |                                      |  | MONTH |  | DAY  |  | YEAR     |  | 2d. HOUR |  |
| female   | white   | 4 2 35   |  | 45  |  | MONTHS                            |  | DAYS                       |  | 3                        |  |                                      |  | 3     |  | 19   |  | 81       |  | 4:40     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                     |  | WIDOWED                    |  | DIVORCED                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  | MD.  |  |          |  |          |  |
| NEW YORK   |         | USA  |  | XX  |  |                                   |  |                            |  |                          |  | Baltimore City                       |  |       |  |      |  |          |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| Baltimore  |         | Sinai Hospital   |  | HOUSEWIFE   |  | AT HOME                           |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS        |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| MARYLAND   |         |  |  | BALTIMORE   |  | YES XX NO                         |  | 3922 ROSECREST AVE. #21215 |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| LOUIS I. MILLER  |         | HELEN J. SHAPIRO   |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| NO   |         | 212-36-7990  |  | GEORGE GERSON   |  | 3922 ROSECREST AVE. #21215        |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 4292   |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| (b)  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| (c)  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
|  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |         | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED                                      |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
|  |         | HOUR A.M. MONTH DAY YEAR                                 |  | P.M. 19   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY                                     |  | 21f. LOCATION   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| WHILE AT WORK NOT WHILE AT WORK  |         | STREET, FACTORY, FARM, ETC.)                             |  | STREET  |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
|  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |         | Autopsy  |  | Inspection  |  | Inquiry                           |  | and in my opinion          |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| death resulted from:   |         | Natural causes   |  | Accident  |  | Suicide                           |  | Homicide                   |  | Undetermined manner      |  |                                      |  |       |  |      |  |          |  |          |  |
|  |         | XX   |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| Hormez R. Guard, M.D.  |         | Assistant  |  | 3/4/81  |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 111 Penn Street, Balto., MD 21201  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION                     |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| BURIAL   |         | 3/4/81   |  | SHEARITH ISRAEL   |  | BALTIMORE                         |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
|  |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                            |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| SOL LEVINSON & BROS., INC.   |         | MAR 6 1981   |  | Rafaela Baber   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |         |  |  |   |  |                                   |  |                            |  |                          |  |                                      |  |       |  |      |  |          |  |          |  |

MAR 6 1981

1941



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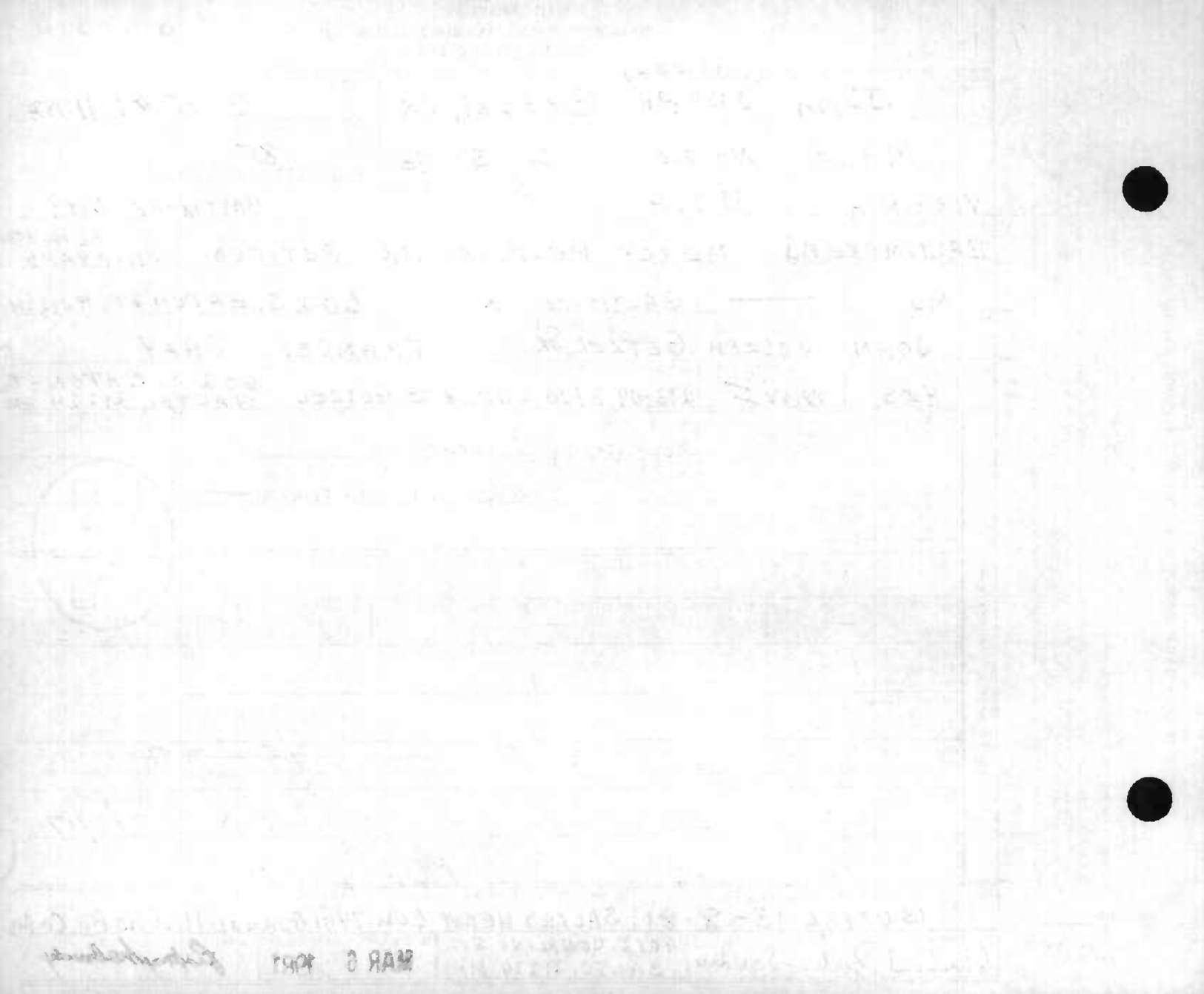
1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST (JOSEPH)   |  | LAST   |  | 3-5-81  |  | 11:15AM   |  |
| 2. SEX  |  | 3. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR   |  |
| MALE  |  | WHITE  |  | 2-5-96   |  | 85 YRS.   |  | MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |
| VIRGINIA  |  | U.S.A.   |  |  |  | BALTIMORE CITY MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| BALTIMORE, MD   |  | MERCY HOSPITAL, INC.   |  | RETIRED  |  | SHIPYARD  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |
| MD  |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 602 S. EATON ST. #2124  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
| JOHN JOSEPH GETZEL, SR.   |  | FRANCES SHAY   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 213-09-3700   |  | LOUISE E. GETZEL 602 S. EATON ST. BALTO. 21224 MD                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>   |  |  |  |  |  |   |  |   |  |
| 4960 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |   |  |
| (b) <u>Severe COPD, pneumonia</u>   |  |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |   |  |
| (c)   |  |  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/81</u> , 19 <u>81</u> , to <u>3/5</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |
| <u>[Signature]</u>  |  | <u>MD</u>  |  | <u>[Signature]</u>   |  | <u>3/5/81</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |
| YEARS <u>04</u>   |  | MERCY HOSP   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |   |  |
| BURIAL  |  | 3-8-81   |  | SACRED HEART CEM   |  | 7401 GERMAN HILL RD. BAL. CO. MD                                    |  |   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |  |
| Name <u>Charles A. Geiler &amp; Son, Inc.</u> ADDRESS <u>901 S. CONKLING ST. BALTO. 21224, MD</u>   |  | MAR 6 1981   |  | <u>[Signature]</u>   |  |   |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 8 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELSIE E. GIBBS</b>                 |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>6</b> YEAR <b>81</b> |   |  | 2b. HOUR<br><b>7:20 PM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>28</b> YEAR <b>91</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF DECEASED IN HOSPITAL, CLINIC, NURSING HOME, ETC.)<br><b>Sinai Hospital</b>  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                             |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. CITY OR TOWN <b>Balto.</b> 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |   |  |
| 13d. STREET ADDRESS<br><b>2449 Shirley Ave.</b>                              |  | 14. FATHER'S NAME<br>FIRST <b>Alonzo</b> MIDDLE <b>Gibbs</b> LAST  |   |   |  |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Julie</b> MIDDLE <b>Montgomery</b> LAST |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |   |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-01-1949</b>                               |  | 17. INFORMANT<br>ADDRESS <b>2636 Openshaw Rd.</b><br><b>John Almony, White Hall, Md. 21161</b>   |   |   |  |   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>possible aspiration</b> <b>error</b> <b>airway obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>aspiration of stomach contents</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic schizophrenia, senility, atherosclerotic cardiovascular disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 minutes</b> |
|---|--|--|

|  |  |   |  |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| <b>Chronic schizophrenia, senility, atherosclerotic cardiovascular disease</b>   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I, this hospital) attended the deceased from <b>8/6/80</b> , 19____, to <b>3/6/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/6</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>(Signature)</b>   |  | 22c. DATE SIGNED<br><b>3/6/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. A. KLEINERMAN, MD</b>   |  | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore<br/>Belvedere at Greenwing Balto, MD 21215</b>                                 |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>March 9, 1981</b>                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Vernon Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN<br><b>White Hall, Balto., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>(Signature)</b>                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>(Signature)</b>             |  | 25c. ADDRESS<br><b>New Freedom, Pa.</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 2 of 2

Baltimore City

none

none

1840 Whitley Ave.

White Montgomery

2535 Greenway Rd. 2121  
John Almon, White Hall, Md.

White Hall, Md.

Baltimore

White

185

Alonso White

no

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White Hall, Baltimore, Md.

Vernon Cemetery

New Freedom, Md.

1851

1851

CCU17 19040428

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |   |   |   |  |   |  |
|---|--|--|--|---|---|---|---|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |  | 8 1 0 6 9 8 8<br>REG. NO.  |   |   |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM M. GILES</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 4, 1981</b>               |   |   |   | 2b. HOUR<br><b>10:03AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 8 23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                     |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CRAN oper.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3354 W. Belvedere Ave</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Giles</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gaines</b>    |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>WALL</b>                                |   | 17. INFORMANT ADDRESS<br><b>Cardenia Lindy 3354 N. Belvedere Ave.</b>             |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYO CARDIAL INFARCTION</b><br><b>410°</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b><br><b>10 yrs</b> |  |  |  |   |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPERTENSION</b>  |  |  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/4</b> 19 <b>80</b> , to <b>3/4</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/4</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>P. Hanley</b>  |  |  | DEGREE<br><b>B.S., M.A., B.H. Sc.</b>                                  |   |   | 22c. DATE SIGNED<br><b>3/5/81</b>   |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. HANLEY</b>   |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                          |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |  | 23b. DATE<br><b>3/7/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>mt. Auburn Cem.</b>                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD.</b>                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles H. Powell F/H</b>  |  |  | ADDRESS<br><b>319 N. Schroeder</b>                                     |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 9 1981</b>                                    |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. Hanley</b>   |   |  |

*Handwritten signature*

MAR 9 1981

RECEIVED  
MAR 10 1981



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Released On Approval by Medical Examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8106989  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Beatrice Winifred Gill  |  |  |  | 2b. MONTH DAY YEAR<br>3 11 81   |  | 2c. HOUR<br>9:18 PM  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 22 1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Rhode Island  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Baltimore Dundalk  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2805 Moorgate Road  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Alick W. Reeves  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Albertina  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>215-70-3381   |  | 17 INFORMANT<br>Donald I. Gill  |  | ADDRESS 2805 Moorgate Rd. Balto., MD. 21222  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u><br>2391<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Chronic Lung Tumor</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Due to, or as a consequence of</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hip fracture to result hip replacement</u>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>3/11/81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fractured Hip  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21b. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21c. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 3 8 1981   |  | 21d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>FALL  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>HOME  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>2805 MORGATE BALTO MD  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11/81 to 3/11/81, that (I) (we) last saw the deceased alive on 3/11/81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Joseph S. Haraay   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>3/11/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HARAAY  |  | 22e. ADDRESS<br>CITY HOSPITAL  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/14/1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Grove  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Boring Baltimore MD.  |  |
| 24 FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.  |  |  |  | 24b. ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06990

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                  |  |   |   |                                |   |  |   |  |  |  |
|--|------------------|--|---|---|--------------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James   |                  | FIRST<br>James   |   | MIDDLE<br>Ginyard   |                                | LAST<br>Ginyard   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>3 20 1981                                   |  | 2b. HOUR<br>M                                |  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 15 14   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>66 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>3 20 1981   |  | 2d. HOUR<br>P 1:50  |  | M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1109 Woodyear Street |   |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Revere copper                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Copper   |  |  |  |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1109 Woodyear St.  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Ginyard  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Francis Byrd   |                                |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  | (IF YES, GIVE WAR OR DATES)  |   | 16b. SOCIAL SECURITY NO.<br>250 12 8969   |                                | 17. INFORMANT ADDRESS<br>Mrs. Cleo Thompson 1128 Woodyear St.                                   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |  |   |   |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |                  |  |   |   |                                |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                  |  |   |   |                                |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |                  | TITLE (SPECIFY)<br>M.D. Deputy Chief   |   |   |                                |   |  | DATE SIGNED<br>3/21/81  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  | ADDRESS<br>111 Penn St. Baltimore, Md.   |   |   |                                |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>3/25/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem.   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Md.                                  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Jas. A. Morton & Sons 1701 Laurens Street  |                  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1981  |                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))  
15M 2/80

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Letter

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 6 9 9 1  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| MICHAEL - GIVENS  |  |  |  | 3 16 81  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| F   |  | CAUC   |  | 4 4 80   |  | 0 YRS. 11 DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MARYLAND  |  | USA.   |  |  |  | BALT. City MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE   |  | UNIVERSITY OF MARYLAND   |  |  |  |  |  |
| 13a. STATE  |  |  |  | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS  |  |
| MARYLAND  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 814 LAFFETTE, ST.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| HARRY   |  | PATRICIA   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| NO  |  |  |  | 814 LAFFETTE, ST, HAVRE de GRACE   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST   |  |  |  |  |  |  |  |
| 7598 DUE TO, OR AS A CONSEQUENCE OF (b) CORNELIA - DE LANGE SYNDROME  |  |  |  |  |  |  | BIRTH  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|   |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16 19 81, to 19 81, that (I) (we) last saw the deceased alive on JANUARY 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Richard R. R. R.  |  |  |  |  |  | 3/16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
| RICHARD R. R. R., MD  |  |  |  | 22 S. GREENE ST BALT, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL  |  | MAR 19 '81   |  | HARFORD MEM. GARDENS   |  | HARFORD, MD.   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REGD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Michele Funeral Home HAVRE DE GRACE, MD.  |  |  |  | MAR 18 1981  |  |  |  |

1913  
March 10  
F

W. H. C. & H. C.  
\* BALT. CITY

BALTIMORE UNIVERSITY  
W. H. C. & H. C.

Hardy T. Evans  
Xin (Baltimore) St. James

CHINESE-AMERICAN  
COLUMBIA - THE GREAT SYMPHONY

1913

1913

1913

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |   |  |   |  |   |   |  |
|---|-------------------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lee Honest Glazebrook, Jr.</b>   |                         |   | 2a. DATE OF DEATH<br>KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>3 24 1981</b> |   |  | 2b. HOUR<br><b>9:40</b>   |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 17, 1927</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>54 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3 24 1981</b>                           | 2d. HOUR<br><b>9:40</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1309 N. Charles Street</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Military-Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cook</b>  |  |
| 13a. STATE<br><b>North Carolina</b>   |                         |   | 13b. COUNTY<br><b>Cumberland</b>   |   | 13c. CITY OR TOWN<br><b>Fayetteville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee Honest Glazebrook, Sr.</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lola Mae Dunning</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Korea &amp; Viet Nam 407-24-8988</b>                 |   |  | 17. INFORMANT<br>ADDRESS <b>Fayetteville, N.C.</b><br><b>Rogers &amp; Breece Funeral Home</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Pneumonia</b>   |                         |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |                         |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |   |  | DATE SIGNED <b>3-25-81</b>  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |                         |   | ADDRESS <b>111 Penn Street</b>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>Mar. 29, 1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cross Creek Cemetery</b>                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Fayetteville, North Carolina</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |                         |   | ADDRESS<br><b>Towson, Md. 21204</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

1991-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

Item 6 g551/01 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 9 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Stanley Ross Gochenour</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>14</b> YEAR <b>1981</b> |   |  | 2b. HOUR<br><b>M</b>   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>13</b> YEAR <b>1916</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> <b>64</b> YRS.   |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3315 Hudson St.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Custodian</b>                                       |  |
| 12b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE <b>MD</b> 12b. COUNTY <b>Baltimore</b> 12c. CITY OR TOWN <b>Baltimore</b>   |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  | 13b. STREET ADDRESS<br><b>3315 Hudson St.</b>   |  |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Howard</b> MIDDLE <b>Lochenour</b> LAST <b>Lochenour</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE <b>Lochenour</b> LAST <b>Lochenour</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(EXCEPT UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>4292</b>   |  | 17 INFORMANT<br><b>Eric Lochenour</b> ADDRESS <b>3315 Hudson St.</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Severe coronary heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>G. P. G. PATTERSON</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/17/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G. P. G. PATTERSON</b>   |  |   |  | 22e. ADDRESS<br><b>3315 Hudson St.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-19-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Phyllis A. Hyman</b> ADDRESS <b>3218 Hudson St.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Phyllis A. Hyman</b>  |  |

My dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

in relation to the order for 1000 copies of the "New York Directory".

The same has been forwarded to the printer and will be ready for delivery in about ten days.

I am, Sir, very respectfully,  
Yours truly,

W. J. B. & S.

Enclosed for you are 100 copies of the "New York Directory".

I am, Sir, very respectfully,  
Yours truly,

W. J. B. & S.

Enclosed for you are 100 copies of the "New York Directory".

I am, Sir, very respectfully,  
Yours truly,

W. J. B. & S.

Enclosed for you are 100 copies of the "New York Directory".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

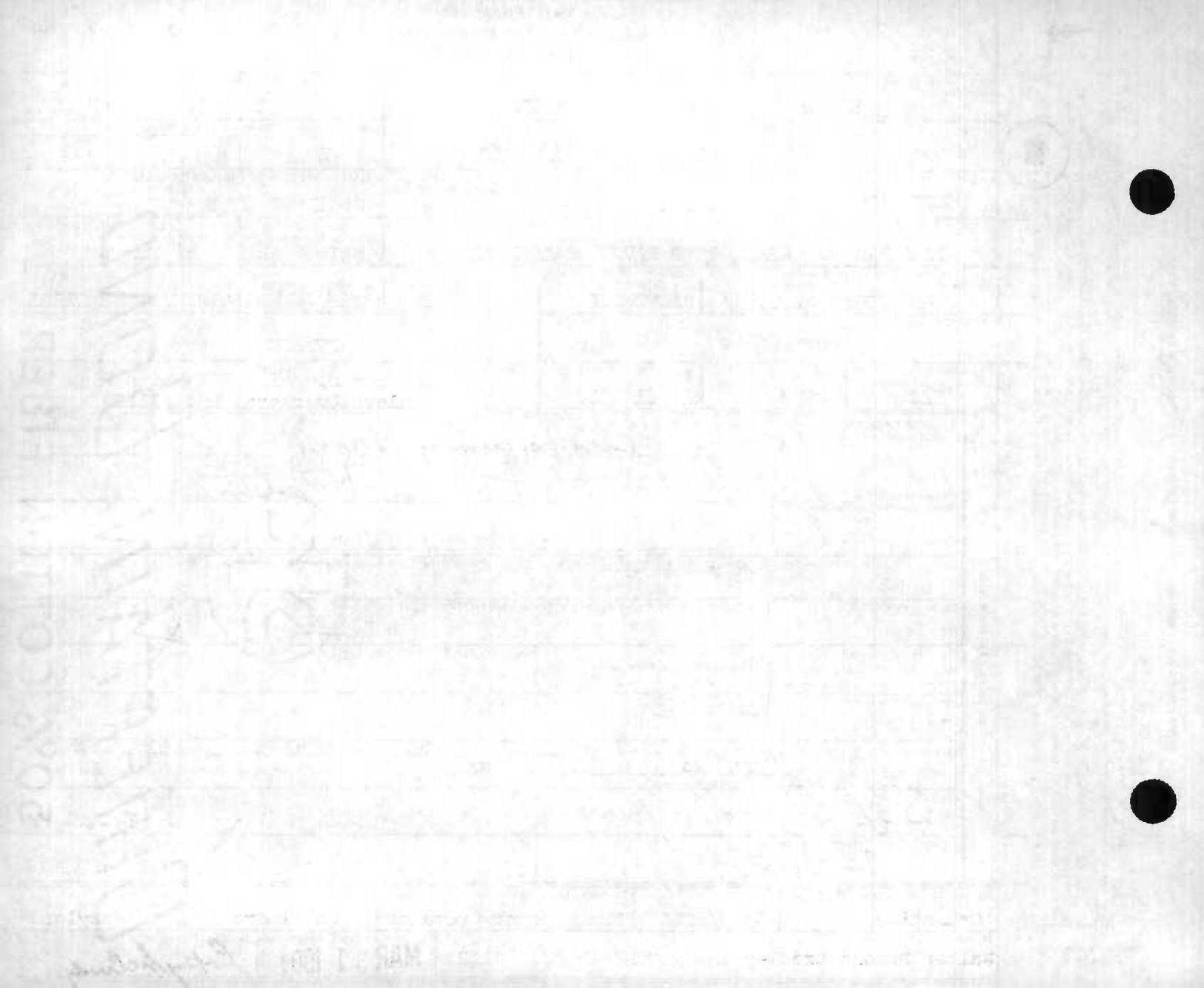
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALFRED (ALBERT) GOETZ</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 81</b>   |  |  |  | 2b. HOUR<br><b>9:54A M</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 93</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>YRS.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, LOCH RAVEN, BALTIMORE, MD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINTENANCE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CEMETERY</b>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1315 XXX EASTERN AVENUE 21221</b>  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>   |  | 17. INFORMANT<br><b>Jeffrey D. Mai</b>  |  | ADDRESS<br><b>3731 White Pine Rd. Bowleys Quarters, Md. 21220</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Prostate Ca - Metastatic</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 17</b> , 19 <b>81</b> , to <b>MARCH 25</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Condor</b>   |  | DEGREE<br><b>CONDOR</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-26-81</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CONDOR</b>  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD., BALTIMORE, MD 21218</b>   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/27/1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc., Dundalk Md. 21222</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara Bradley</b>  |  |  |  |   |  |   |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 6 9 9 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RENA</b>   |  |  | FIRST MIDDLE LAST<br><b>GOLDBERG</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 2 1981</b>   |  |  | 2b. HOUR<br><b>3:01AM</b>   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 15, 1900</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OWNER</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |  | 13b. COUNTY<br><b>BALTO.</b>  |  |  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIDNEY</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  | 13e. STREET ADDRESS<br><b>3714 DOWNEY DALE DR. #21133</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>            |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br><b>SIDNEY GOLDBERG</b>   |  |  | 3714 DOWNEY DALE DR., RANDALLSTOWN, MD 21133  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a)  
**4275**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Respiratory Arrest**  
**Cardiac Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 hours**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> , 19 <b>81</b> , to <b>3/2</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>MT Kees</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/2/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEATING</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hosp.</b>                                     |  |  |  |

|  |  |                            |  |  |  |   |  |
|--|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>3/3/81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOGAN ABRAHAM</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1981</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |  |

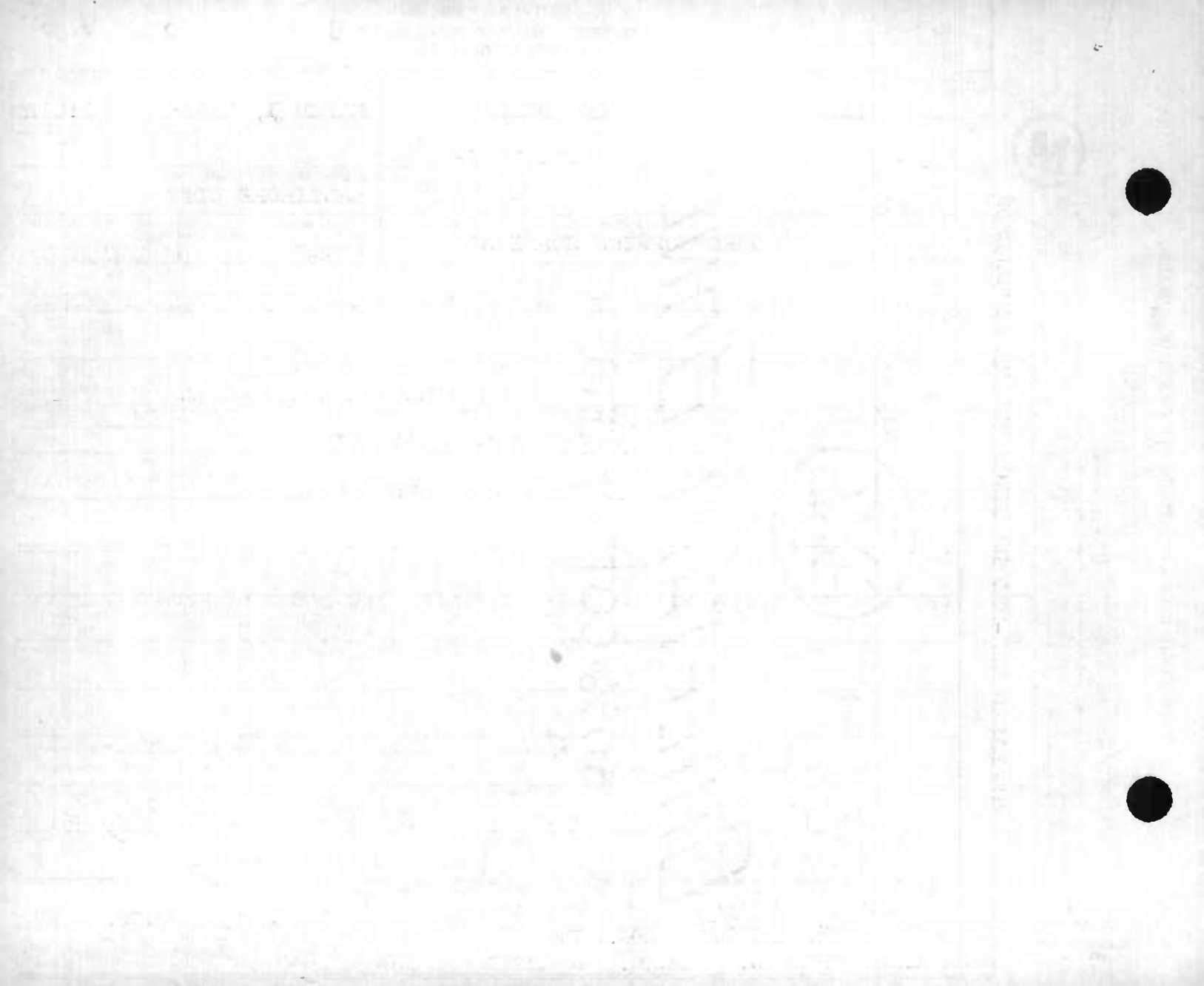
RELEASED NON-MED DR DIXON PER MR RICHARDSON  
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



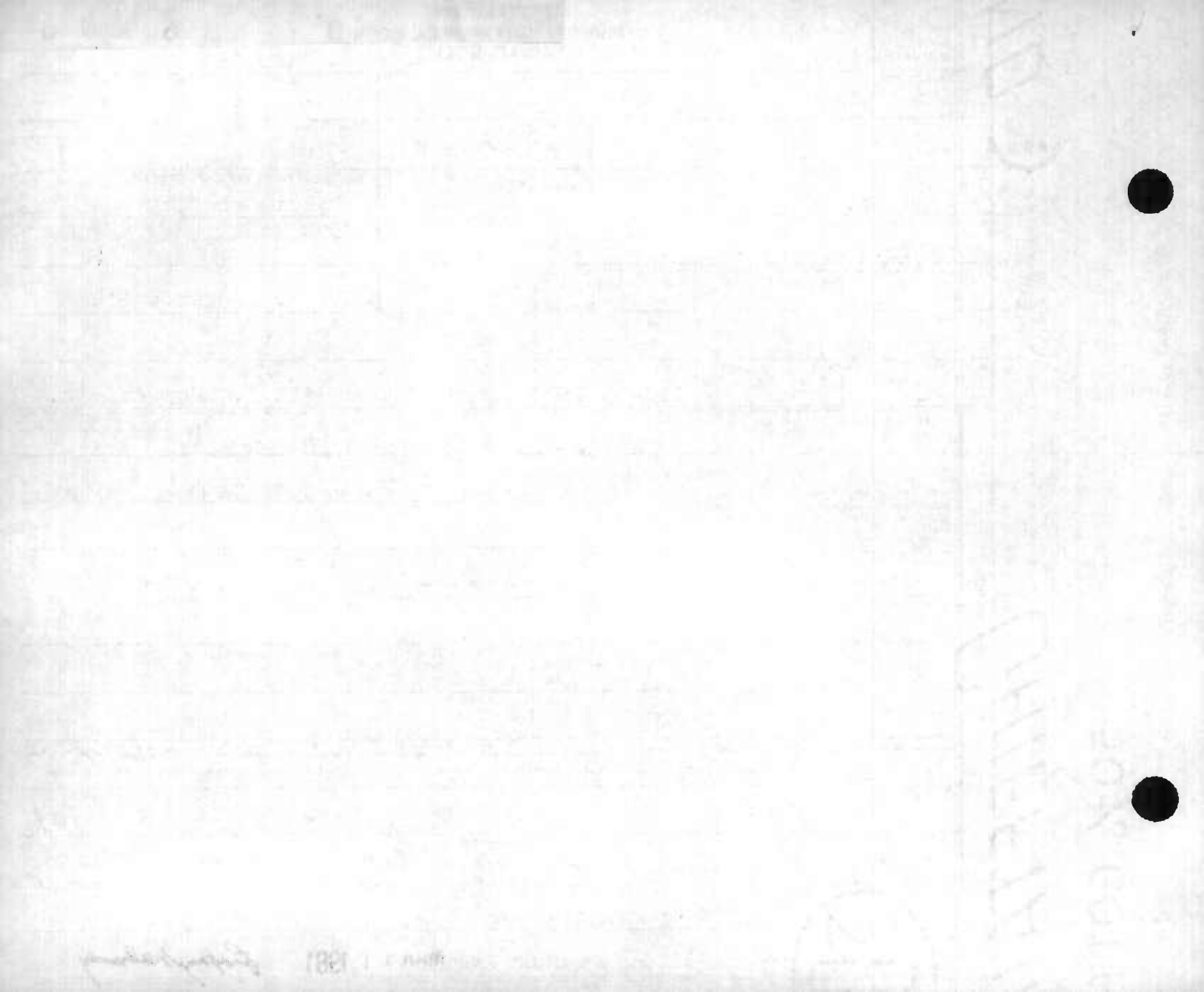
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |                                  |   |  |  |
|--|--|--|--|---|---|--|----------------------------------|---|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |                                  |   |  |  |
| REG. NO.   |  |  |  |   |   |  |                                  |   |  |  |
| 1. FOR STATE REGISTRAR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                |  |                                  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  |   | 2b. HOUR  |  |                                  |   |  |  |
| Lena M. Goode  |  |  |  |   | 3 8 81 M  |  |                                  |   |  |  |
| 3. SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.                                   |                                  | IF UNDER 1 YEAR MONTHS DAYS   |  |  |
| F  |  | B  |  | 6 30 99   |   | 81   |                                  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |                                  |   |  |  |
| Va.  |  | USA  |  |   |   | Baltimore City MD  |                                  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)          |                                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| Balto.   |  | 411 N. Edgewood St.  |  |   |   |  |                                  |   |  |  |
| 13a. STATE   |  |  |  |   | 13b. COUNTY                                     |  | 13c. CITY OR TOWN                |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Md.  |  |  |  |   |   |  | Balto.                           |   | 13e. STREET ADDRESS  |  |
|  |  |  |  |   |   |  | 411 N. Edgewood St.              |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST      |  |                                  |   |  |  |
| James Marshall   |  |  |  |   | Nan Keene                                       |  |                                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |   | 16b. SOCIAL SECURITY NO.                        |  | 17. INFORMANT ADDRESS            |   |  |  |
| No   |  |  |  |   | 215-32-7828                                     |  | Junuis Goode 411 N. Edgewood St. |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |  |                                  |   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |   |  |                                  |   |  |  |
| IMMEDIATE CAUSE (a) <i>4029 Congestive Cardiac failure</i>   |  |  |  |   |   |  |                                  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Atherosclerotic CVD</i>   |  |  |  |   |   |  |                                  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |   |  |                                  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Uremia, Multiple cerebrovascular accidents, UTI</i>  |  |  |  |   |   |  |                                  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                                  |   |  |  |
|  |  | P.M. 19  |  |   |   |  |                                  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |                                  |   |  |  |
|  |  |  |  |   |   |  |                                  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-20</i> , 19 <i>81</i> , to <i>3-8</i> , 19 <i>81</i> , that (we) lost saw the deceased alive on <i>3-7</i> , 19 <i>81</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death. |  |  |  |   |   |  |                                  |   |  |  |
| 22b. SIGNATURE <i>M. J. Shafr</i> MD   |  |  |  |   | 22c. DATE SIGNED <i>3/10/81</i>                 |  |                                  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |
| JAVAD MUHAMMAD SHAFI   |  |  |  |   | 22e. ADDRESS <i>2300 GARRISON BLVD MD 21216</i> |  |                                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |                                  |   |  |  |
| Burial   |  | 3/14/81  |  | Baltimore Cem.  |   | Baltimore, Md.   |                                  |   |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR                   |  |                                  |   |  |  |
| Wm C March F/H   |  |  |  |   | 1101 E. North Ave. MAR 11 1981                  |  |                                  |   |  |  |
|  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE <i>Forney</i>        |  |                                  |   |  |  |

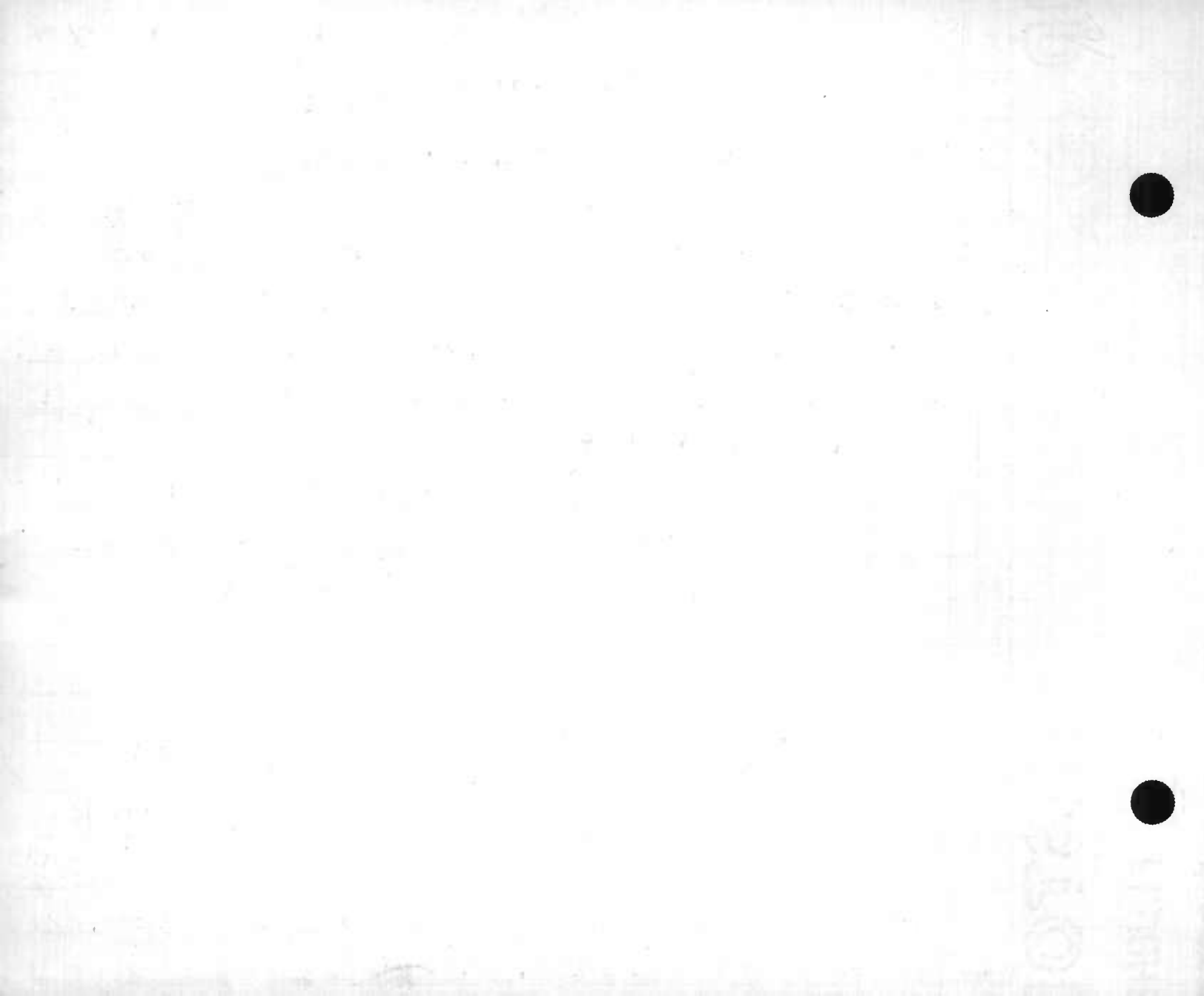


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |   |  |  |  |
|---|--|---|--|---|---|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7. REG. NO.   |  | 8 1 0 6 9 9 7   |   |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARTHA   |  | FIRST MIDDLE LAST<br>Martha Ellen Goodhand  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/6/81 3/6/81  |   |   | 2b. HOUR<br>1 45 P.M.  |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 1, 1894   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home       |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br>Maryland Baltimore  |  |   |  | 13c. CITY OR TOWN<br>Arbutus  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>5420 Highridge St. 21227 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ulysses G. Tyson  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah D. (Tyson) UKN.  |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT<br>ADDRESS<br>Mr. William T. Goodhand Same as #13   |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Lower lobe pneumonia</u><br>(c) <u>Chronic heart failure</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Heart failure</u> |  |   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>81</u> , to <u>3/6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |   |  | 22b. DATE SIGNED<br>3/6/81                   |  |
| 22c. SIGNATURE<br>BERNARD D. GONZALEZ JR.   |  |   |  | 22d. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   |   |  |   |  |  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bernard D. Gonzalez  |  |   |  | 23b. ADDRESS<br>Bon Secours Hospital - Baltimore  |   |   |  |   |  |  |  |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23d. DATE<br>3/9/81   |  | 23e. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |   | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore, Md.                           |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home  |  |   |  | 25. ADDRESS<br>301 Frederick Rd. Catonsville, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]       |  |  |  |

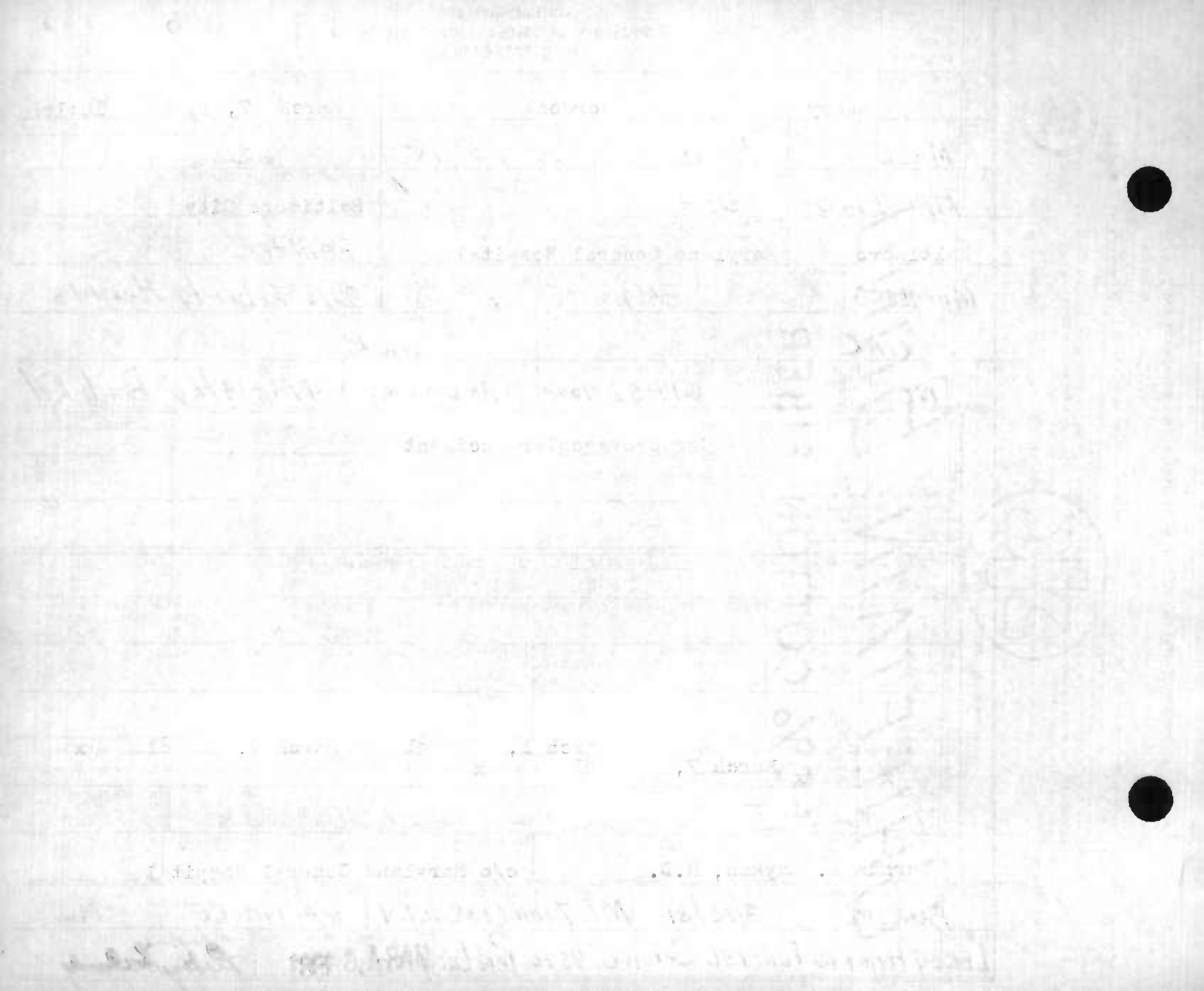


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 6 9 9 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| I. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR  |  |  |  |
| Henry Gordon   |  |  |  | March 7, 1981   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE   |  | Negro  |  | MONTH DAY YEAR<br>10 13 18  |  | 62 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MARYLAND   |  | USA  |  |   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Maryland General Hospital  |  | PAINTER   |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| MARYLAND   |  |  |  |   |  | BALTIMORE  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST   |  |  |  |
| UNK  |  |  |  | UNK   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |
| NO   |  | 219-52-4603  |  | PEARL Cole 194 Magathly Beach Rd.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1, 1981, to March 7, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 7, 1981, and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Turhan I. Baykan M.D.  |  | 22c. DATE SIGNED<br>3.7.81  |  | 22d. ADDRESS<br>c/o Maryland General Hospital                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| BURIAL   |  | 3/13/81  |  | MT. ZION CEMETERY   |  | BALTIMORE MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>LEROY HARRIS Funeral Service 4520 Pen Luc  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
|  |  |  |  | MAR 16 1981   |  | Leroy Harris   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |   |  |  |  | REG. NO. 06999   |  |
|--|--|---------------|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Charles E. Gore  |  |               |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3 6 19 81   |  | 2b. HOUR 12:32 P M   |  |
| 3. SEX Male  |  | 4. RACE White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR Oct. 21, 1914  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) 66 YRS.                                    |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD 3 7 19 81   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 331 S. Payson Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY Painter  |  |
| 13a. STATE Maryland  |  |               |  | 13b. CITY City  |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 331 Payson Street  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Oliver G. Gore  |  |               |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Lulu Todd   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) XXXX YES WW11  |  |               |  | 16b. SOCIAL SECURITY NO. 218-14-0769  |  | 17. INFORMANT ADDRESS Elsie G. Gore, 204 E, Joppa Road 21204                  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |               |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |               |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |               |  | TITLE (SPECIFY) Assistant   |  |   |  | MEDICAL EXAMINER   |  | DATE SIGNED 3/8/81   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |               |  | ADDRESS 111 Penn Street   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  |               |  | 23b. DATE 3-9-81  |  | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE Baltimore, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |               |  |   |  | 25a. DATE REC'D. BY REGISTRAR MAR 10 1981                                     |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

*[Handwritten signature]*

MAR 11 1981

|  |  |  |  |  |  |   |  |                     |  |   |  |
|--|--|--|--|--|--|---|--|---------------------|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY   |  | YEAR                |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 3/15/81             |  | 12:20 M   |  |
| HENRY J. GORECKI   |  |  |  |  |  |   |  |                     |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS                                   |  |
| MALE   |  | WHITE  |  | 10 19 07   |  | 73 YRS  |  | MONTHS              |  | DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | CITY                |  | Baltimore MD.                                     |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | BALTIMORE           |  | University of Md. RETIRED Compositor-Printing Co. |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS |  |   |  |
| MD   |  | BALTO CITY   |  | BALTO  |  |   |  | 3652 ELLERSHIE AVE  |  |   |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME  |  | MIDDLE              |  | LAST  |  |
| Peter  |  |  |  | GORECKI  |  | WANDA   |  |                     |  | CHODKOW AKA                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |   |  |
| no   |  | 212-10-2918  |  | Mrs Amelia R. Gorecki  |  | same  |  |                     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                     |  |   |  |
| 1850   |  | CARDIOPULMONARY ARREST   |  | RENAL FAILURE  |  |   |  |                     |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | CANCER OF PROSTATE  |  |                     |  |   |  |
| (c)  |  |  |  |  |  |   |  |                     |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |                     |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                     |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                     |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23, 19 81 to 3/14/19 81, that (I) (we) last saw the deceased alive on 3/14/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE K. Shaw - Jay W   |  | 22c. DATE SIGNED 3/15/81   |  |   |  |                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Shaw - Jay W  |  | 22e. ADDRESS UMH   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>          |  |   |  |                     |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE Mar. 19, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  | Baltimore, Maryland |  |   |  |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR MAR 16 1981  |  | 25b. REGISTRAR'S SIGNATURE  |  |                     |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. FREDRICK STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 7 0 0

| FOR<br>1- STATE<br>REGISTRAR  |                  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |   |  |                     | 07001<br>REG. NO.  |                               |
|---|------------------|--|---|--|---------------------|--|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DENNIS B. GORHAM   |                  |  |   | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED<br>X MONTH DAY YEAR<br>3 29 19 81   |                     | 2b. HOUR<br>M<br>11:48<br>P M  |                               |
| 3. SEX<br>male  | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 10 1958  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>22 YRS. | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 8. IF UNDER 24 HRS. | 9. DATE<br>PRONOUNCED<br>DEAD<br>3 29 19 81  | 10. HOUR<br>M<br>11:48<br>P M |
| 11. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md  |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U S A  |   | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 14. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |                               |
| 15. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>alley - 1100 blk. Patterson Pk. Ave. |   |  |                     | 17. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>18. KIND OF BUSINESS<br>OR INDUSTRY |                               |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>19a. STATE<br>Md  |                  |  |   | 19b. CITY OR TOWN<br>Balto   |                     | 19c. STREET ADDRESS<br>1604 N Port Street  |                               |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ollie C Gorham Sr.  |                  |  |   | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ramona S. Howel   |                     |  |                               |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |                  |  |   | 23. SOCIAL SECURITY NO.<br>212-76-0360   |                     | 24. INFORMANT<br>Dorothy Ellis 1727 E. Lafayette Ave   |                               |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot wound to chest (unspecified weapon)<br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |                  |  |   |  |                     |  |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |  |   |  |                     |  |                               |
| 26. DATE OF OPERATION   |                  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |                     | 28. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                               |
| 29. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 30. TIME OF INJURY<br>HOUR MIN MONTH DAY YEAR<br>1:30 AM 3-29-19 81  |   | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot.  |                     |  |                               |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |                  | 33. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>alley   |   | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1100 blk. Patterson Pk. Ave., Balto. City Md.  |                     |  |                               |
| 35. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |  |                     |  |                               |
| 36. ACTUAL<br>SIGNATURE<br>Ann M. Bixon, M.D.   |                  | 37. TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |   |  |                     | 38. DATE<br>SIGNED 3-30-81   |                               |
| 39. EXAMINER'S NAME<br>(TYPE OR PRINT)  |                  | 40. ADDRESS<br>111 Penn St.  |   |  |                     |  |                               |
| 41. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 42. DATE<br>4/2/81   |   | 43. NAME OF CEMETERY OR CREMATORY<br>Md Veteran Cemetery   |                     | 44. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville Md  |                               |
| 45. FUNERAL DIRECTOR<br>NAME<br>William C. March E/H 1101 E. North Ave  |                  |  |   | 46. DATE REC'D. BY REGISTRAR<br>MAR 31 1981  |                     | 47. REGISTRAR'S SIGNATURE  |                               |



*Handwritten signature or mark.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 7 0 0 2  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |
| REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>ANNA GOTTlieb</i>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 / 13 / 81</i>  |  | 2b. HOUR<br><i>150 P M</i>   |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 23 93</i>   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>AUSTRIA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>SINAI HOSPITAL</i> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto City</i> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |  |  |  |
| 13a. STATE<br><i>MARYLAND</i>  |  | 13b. COUNTY<br><i>BALTIMORE</i>  |  | 13c. CITY OR TOWN<br><i>OWINGS MILLS</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>BENJAMIN BRIER</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>125-40-1512</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>MR. HERMAN LITPMAN</i><br><i>6318 GREENSPRING AVE., APT. 307 #21209</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4441</i> IMMEDIATE CAUSE (a) <i>Aortic Thrombosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Diffuse Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Right Brachial artery embolus</i>  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>3/9/81</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Right Brachial arterioembolus</i>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/6</i> , 19 <i>81</i> , to <i>3/13</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>3/13</i> , 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (If we) did not view the body after death.                              |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Richard Damewood</i>  |  |  |  | 22c. DATE SIGNED<br><i>3-13-81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Richard Damewood</i>   |  |  |  | 22e. ADDRESS<br><i>Sinai Hospital - Greenspring - Belvoir</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>3-15-81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>NEW HAR SINAI CONG.</i>                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>OWINGS MILLS BALTO. MD</i>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i><br>ADDRESS<br><i>6010 REISTERSTOWN RD., BALTO., MD 21215</i>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAK 19 1981</i>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frederick M. Brady</i>  |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF  
PLANT INDUSTRY

WASHINGTON, D. C.

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Handwritten signature or initials.

1901 8 2 JAN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                                   |  |
|---|--|---|---|---|-----------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ira EMMA Grady</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 21, 1981</b>    |   | 2b. HOUR<br><b>2:00p M</b>        |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 15 1912</b>  |                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N. CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |                                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |                                   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>                |   |                                   |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>BALTO</b>                                     |   | 13c. CITY OR TOWN<br><b>BALTO</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b> |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>4280</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>EDGAR GRADY 1623 FILBERT ST</b>  |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver Failure, Renal Failure</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure, Anoxic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Encephalopathy, Perforated, Intestinal Viscus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |                                   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF INJURY, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>February 23</b> , 19 <b>81</b> , to <b>March 21</b> , 19 <b>81</b> , that (1) (we) lost<br>saw the deceased alive on <b>March 21</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (X) (we) (did not) view the body after death.   |  |   |   |   |                                   |  |
| 22b. SIGNATURE<br><b>Susan Schwartz</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3/21/81</b>  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Susan Schwartz, M.D.</b>  |  | 22e. ADDRESS<br><b>Care of Maryland General Hospital</b>  |   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-24-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAKLAND CEM</b>  |                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>   |   |   |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOHN M. WEBER</b>  |  | ADDRESS<br><b>401 S CHESTER</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                   |  |

MEDICAL CERTIFICATION

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2664BP 4

Baltimore City

Maryland General Hospital

Baltimore

Encephalopathy, Perforated, Intestinal Viscus  
Congestive Heart Failure, Toxic  
Liver Failure, Renal Failure

xx x  
March 21  
February 23  
March 21  
March 21  
xx

Susan Schwartz, M.D.  
Care of Maryland General Hospital

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |                                   |   |  |
|--|--|--|--|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DONALD C. GRAHAM</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>30</b> YEAR <b>1981</b> |   |  | 2b. HOUR<br><b>M</b>  |  |  |                                   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>August</b> DAY <b>12</b> YEAR <b>1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |                                   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5608 Tramore Rd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Man- Real Estate</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |                                   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b></b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>5608 Tramore Rd.</b>   |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>Crawford</b> LAST <b>Graham</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Edna</b> MIDDLE <b>Clara</b> LAST <b>Wetzel</b>  |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-5625</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ethel M. Graham Same as # 13e</b>                             |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic heart disease</b><br>3 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>3 yrs</b> |  |  |  |   |  |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Duodenal ulcers.</b>  |  |  |  |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/22</b> , 19 <b>78</b> , to <b>3/30</b> , 1981, that (I) <del>last</del> saw the deceased alive on <b>3/18</b> , 19 <b>81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do not</del> (did not) view the body after death.                |  |  |  |   |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Conrad Richter</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>4/4/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Conrad Richter, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>3128 Harford Rd.</b>   |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>Apr. 1, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Balto., Md.</b>   |  |  |  |   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1981</b>  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony M. Brady</b>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  | REG. NO. 07005  |  |  |  |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Herbert Grant   |  |  |  |  |  |   |  |   |  | 2. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3 7 19 81                               |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2-13-1917  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>64 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 10 19 81                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD  |  |   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2503 N. Calvert Street |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY --- 13c. CITY OR TOWN Baltimore   |  |  |  |  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2503 North Calvert St |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>246-16-4667   |  |   |  | 17. INFORMANT ADDRESS   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration of food bolus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY estimated<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 3 7 19 81  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject choked on food |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2503 N. Calvert St., Baltimore Md.                 |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan</u>   |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  | DATE SIGNED<br>3/10/81  |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>REMOVAL   |  |  |  | 23b. DATE<br>3-24-81   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Baord of Md.   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McBrady</u>          |  |   |  |  |  |

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80



10-10-66

1001 North Calaveras St

Calaveras

1001-10-66

1001-10-66

1001-10-66

Calaveras

1001-10-66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

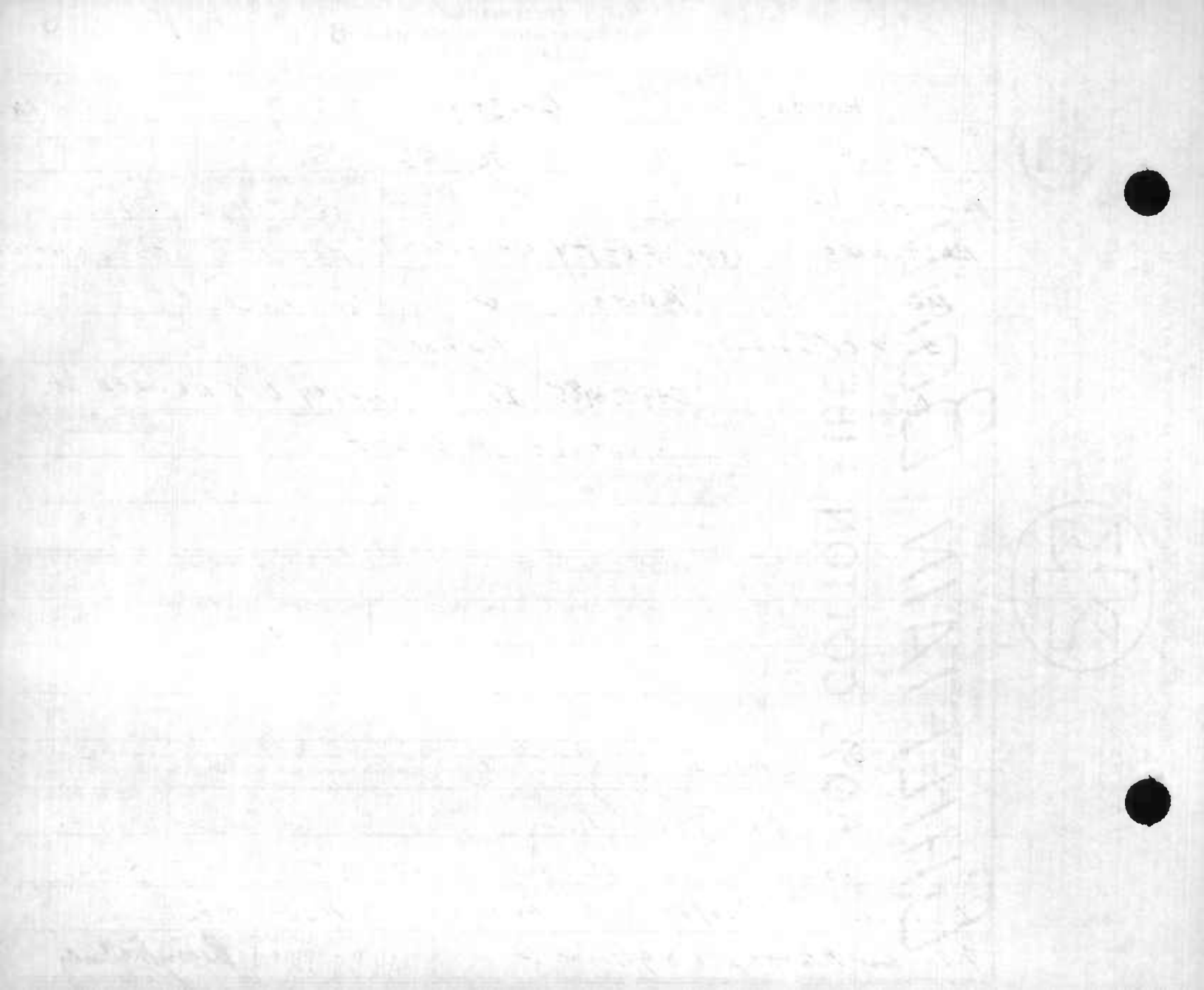
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REG. NO.

|   |  |  |   |  |   |  |
|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HOWARD GRASTY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-20-81</b>           |  | 2b. HOUR<br><b>5:05 AM</b>                      |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 16 46</b>   |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>DANVILLE VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)<br><b>UNIVERSITY HOSPITAL</b>                   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GAS &amp; ELECTRIC</b>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>                                   |   | 13b. COUNTY<br><b>BALTO.</b>   |   |  |
| 13c. CITY OR TOWN<br><b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>605 ARCHER ST</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN GRASTY</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FANALIE</b> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>244-030985</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>IRENE GRASTY 605 ARCHER ST</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>—   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>FEB 5</b> , 19 <b>81</b> , to <b>MAR 20</b> , 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>MAR 20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>John H. Weigel MD</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3-20-81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN H. WEIGEL MD</b>   |  | 22e. ADDRESS<br><b>22 S. GREENE ST - BALTO 2201</b>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/24/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT ARBURN</b>   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter A. Bump 635 S. GREENE ST</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>   |  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   |   |                                  |   |   |  |  |
|---|--|---|---|---|----------------------------------|---|---|--|--|
| 1- FOR STATE REGISTRAR<br>David Alexander GRAY  |  |   |   |   | REG. NO. 8107007                 |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>GRAY DAVID A  |  |   |   |   | 2a. DATE OF DEATH<br>3/16/81     |   |   | 2b. HOUR<br>12 M   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro  |   | 5. DATE OF BIRTH<br>May 15 1914   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                       |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Of Maryland Hosp.       |   |   |                                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Builder |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Calvert  |   | 13c. CITY OR TOWN<br>St. Leonard |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Norman A. Gray  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosa Bourne        |   |                                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no     |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>220-07-9782   |  |   | 17. INFORMANT ADDRESS<br>Dorothy Gray P.O. Box 12, St. Leonard, Md. |   |                                  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest<br>2080 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute Non lymphocytic Leukemia<br>(c) Possibly overwhelming sepsis<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Fungal Pneumonia |  |   |   |   |                                  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10/81, 19, to 3/16/81, 19, that (I) (we) lost saw the deceased alive on 3/16/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |                                  |   |   |  |  |
| 22b. SIGNATURE<br>JAI JOSHI MD  |  | DEGREE  |   | 22c. DATE SIGNED<br>3/16/81   |                                  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAI JOSHI MD  |  |
| 22e. ADDRESS<br>BCRP, UNIV. OF MD   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |                                  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 21-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Brooks Chr. Cem.  |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St. Leonard Calvert Md.       |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Spencer E. Sewell   |  | 24b. ADDRESS<br>Box 31, Prince Frederick, Md.   |   | 25a. DATE REG'D. BY REGISTRAR<br>MAR 20 1981  |                                  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy Gray                                  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Odyssey E. Gray</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>17</b> YEAR <b>81</b> |   |  | 2b. HOUR<br><b>8:02</b> AM  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>2</b> YEAR <b>19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Leonard</b> MIDDLE <b>M.</b> LAST <b>Gray</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Glady's</b> MIDDLE <b>MURPHY</b> LAST <b>MURPHY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-16-2555</b>  |  | 17. INFORMANT<br><b>Mrs. Marie A. Gray</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>4439<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Probable myocardial infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>STATUS POST Aortic aneurysmectomy and bypass</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>STATUS POST Aortic aneurysmectomy and bypass</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>3/10/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CLAUDICATION</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10/81</b> to <b>3/17/81</b> , that (I) (we) lost saw the deceased alive on <b>3/17/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Jeanne Alicandro</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/18/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEANNE ALICANDRO</b>   |  |   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-21-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brooks Chapel Cemetery Calvert County Maryland</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>   |  | 25b. REGISTERING PHYSICIAN<br><b>Jeffrey M. Murphy</b>  |  |

24. FUNERAL DIRECTOR  
NAME  
**Herbert E. Nutter**

25a. DATE REC'D. BY REGISTRAR  
**MAR 19 1981**

25b. REGISTERING PHYSICIAN  
**Jeffrey M. Murphy**

(over)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 07009

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |   |  |
|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSA P. GRAY.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-8-81</b> |   |   | 2b. HOUR<br><b>1:30 PM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 23 13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  |
| 7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City, Baltimore</b> MD                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>               |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br><b>William</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Hannah</b>  |  | 13e. STREET ADDRESS<br><b>1100 Pennsylvania Ave 614</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-22-4674</b>   |  | 17. INFORMANT<br><b>Elizabeth Miller</b> ADDRESS<br><b>7241 Sawmill Branch Rd.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST.</b><br>4/100<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last<br>(b) <b>PNEUMONIA</b><br>(c) <b>MI?, PULMONARY EMBOLISM?</b>                 |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> 19 <b>81</b> , to <b>3/8</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>GASPAR DEL MONTE</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br><b>3/8/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GASPAR DEL MONTE M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>2600 Liberty Heights.</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b>                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM.C. MARCH F/H INC.</b>   |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1981</b>   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 0 1 0  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

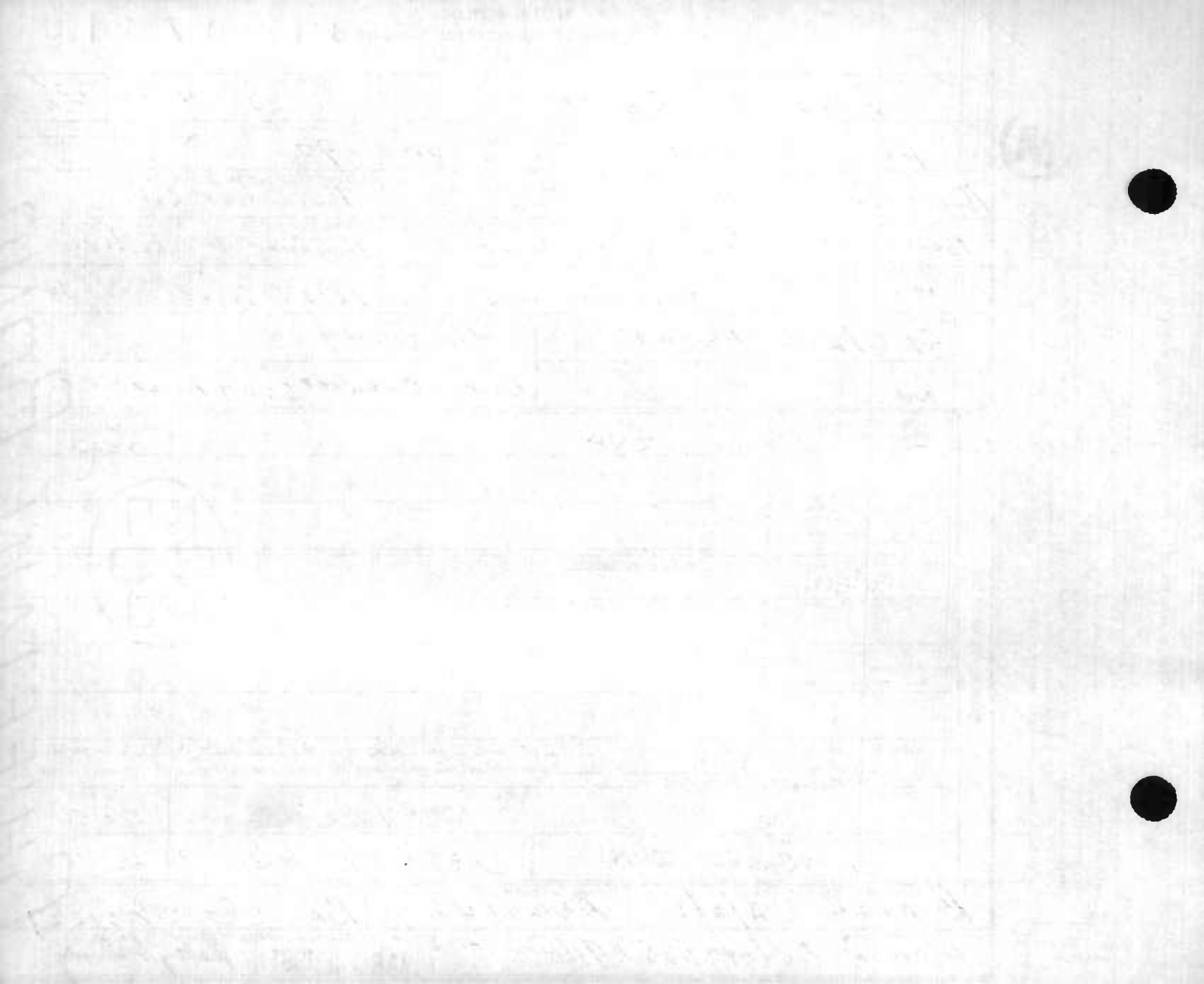
REG. NO.

|  |  |  |   |   |  |   |   |
|--|--|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LONA D GREEN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>4</b> YEAR <b>81</b> |   |  | 2b. HOUR <b>6:45</b> MIN. <b>M</b>  |   |
| 3. SEX <b>F.</b>   |  | 4. RACE <b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>1</b> YEAR <b>90</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEWISIAN CONV. HOME</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWORK</b>                                       |   |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>   |  | 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>   |   |   |  |   |   |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1612 N SMALLWOOD ST</b>   |   |   |  |   |   |
| 14. FATHER'S NAME<br>FIRST <b>STELLA</b> MIDDLE <b>BROWN</b> LAST <b>BROWN</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>4360</b>   |   | 17. INFORMANT ADDRESS <b>DAVID DUCKERT 3809 NORTON AVE</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                        |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>day</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ANEMIA</b>   |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>27 DEC</b> , 19 <b>80</b> , to <b>69</b> <b>1st</b> , 19 <b>81</b> , that (we) lost<br>saw the deceased alive on <b>3-4</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |   |   |  |   |   |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>   |  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED <b>3/6/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ARTHUR LERSON</b>   |  |  |   | 22e. ADDRESS <b>3640 FORDS LANE 21215</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  | 23b. DATE <b>3/6/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>ARBURUS</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MD</b> STATE <b>MD</b>   |   |
| 24. FUNERAL DIRECTOR <b>THOMAS A. STAYN 6387 9th Ave. St</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 10 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |  |  |  |  | 8   | 1 | 0 | 7 | 0 | 1 | 1 |
|---|--|--|--|--|--|--|--|--|--|---|---|---|---|---|---|---|
| FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |   |   |   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |   |   |   |   |   |   |
| Ethel Beatrice Green  |  |  |  |  |  |  |  |  |  | 3-1-81  |   |   |   |   |   |   |
| 3. SEX<br>F   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br>1225 AM   |   |   |   |   |   |   |
| 4. RACE<br>B  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH  |   |   |   |   |   |   |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 19 05   |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |   |   |   |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |   |   |   |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City Balto. MD.   |   |   |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore Md   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hosp |   |   |   |   |   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |   |   |   |   |   |   |
| 13a. STATE<br>Md  |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN<br>City Balto.  |   |   |   |   |   |   |
| 13c. CITY OR TOWN<br>Balto.   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |   |   |   |   |   |   |
| 13e. STREET ADDRESS<br>217 Monastery Ae   |  |  |  |  |  |  |  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Victor Hines  |   |   |   |   |   |   |
| 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Martha E. Llorbe   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>X   |   |   |   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br>218-18-3978   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Randallstown, Md. 21133<br>Mrs. Veronica Hardy 18 Coachman Court                                |   |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>3319<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Stroke<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Generalized cerebral atrophy.                   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   |   |   |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |   |   |   |   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   |   |   |   |   |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-20 1981 to 2-7 1981, that (I) (we) lost saw the deceased alive on 3-1 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |
| 22b. SIGNATURE<br>G. Shah   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>3/1/81  |   |   |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. G. SHAH.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL.   |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>3-5-81   |   |   |   |   |   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel County, Md.  |   |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter Funeral Home  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1981   |   |   |   |   |   |   |
| 25b. REGISTRAR'S SIGNATURE<br>Rafael M. Brady   |  |  |  |  |  |  |  |  |  |   |   |   |   |   |   |   |



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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Leroy Green</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 4 81</b>  |  | 2b. HOUR<br><b>8: a.m.</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 15 1924</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56 YRS.</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1657 ARGONNE DR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOCKMAN</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>R. Road</b>  |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1657 ARGONNE DR.</b>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAM GREEN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORINE THOMPSON</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>351-22-6284</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>CAROLYN GREEN 1657 ARGONNE DR.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>1460</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Squamous cell carcinoma of tonsil</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min.</b><br><b>7 months</b>  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 18, 1980</b> , to <b>Feb. 27, 1981</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 2, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 23a. SIGNATURE<br><b>Ding-Jen Lee M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3/5/81</b>  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ding-Jen Lee, M.D.</b>   |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3-7-81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nth. Calvary Cmty.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cedar Hill B.A.Co. Md.</b>          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Randolph J. Collick</b>   |  | ADDRESS<br><b>2431 E. Oliver St.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1981</b>                                   |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Karyn Maloney</b>                                   |  |

NO. 11111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 5, 6, 8553 3/31/81 g3

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8107013

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY A. Green</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>81</b>  |  | 2b. HOUR<br><b>2:01 P.M.</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>11</b> YEAR <b>18</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                 |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md</b>  | 13b. CITY OR TOWN<br><b>Balto.</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13d. STREET ADDRESS<br><b>992 Franklin Ave</b>                    |  |   |
| 14. FATHER'S NAME<br>FIRST <b>Nelson</b> MIDDLE <b></b> LAST <b>Shorts</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE <b></b> LAST <b></b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b></b>   |   | 17. INFORMANT<br><b>Woodrow W. Green</b> ADDRESS<br><b>992 W. Franklin Ave</b> RE    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Anemia</b><br>(b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Breast Cancer</b><br>(c) <b>Atherosclerosis</b>                                    |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>4 weeks</b><br><b>3 years</b>                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Breast Cancer 2 years</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b></b> <b></b> <b></b> <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> , 19 <b>81</b> , to <b>3/11</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Philip Konits</b>   |  | DEGREE<br><b>BCRP</b>   |   | 22c. DATE SIGNED<br><b>3/11/81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Konits</b>  |  | 22e. ADDRESS<br><b>BCRP</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3/14/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Arbutus, Md.</b> COUNTY <b></b> STATE <b></b>       |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 16 1981</b> 25b. REGISTRAR'S SIGNATURE<br><b>Mary McHenry</b>  |   |  |   |



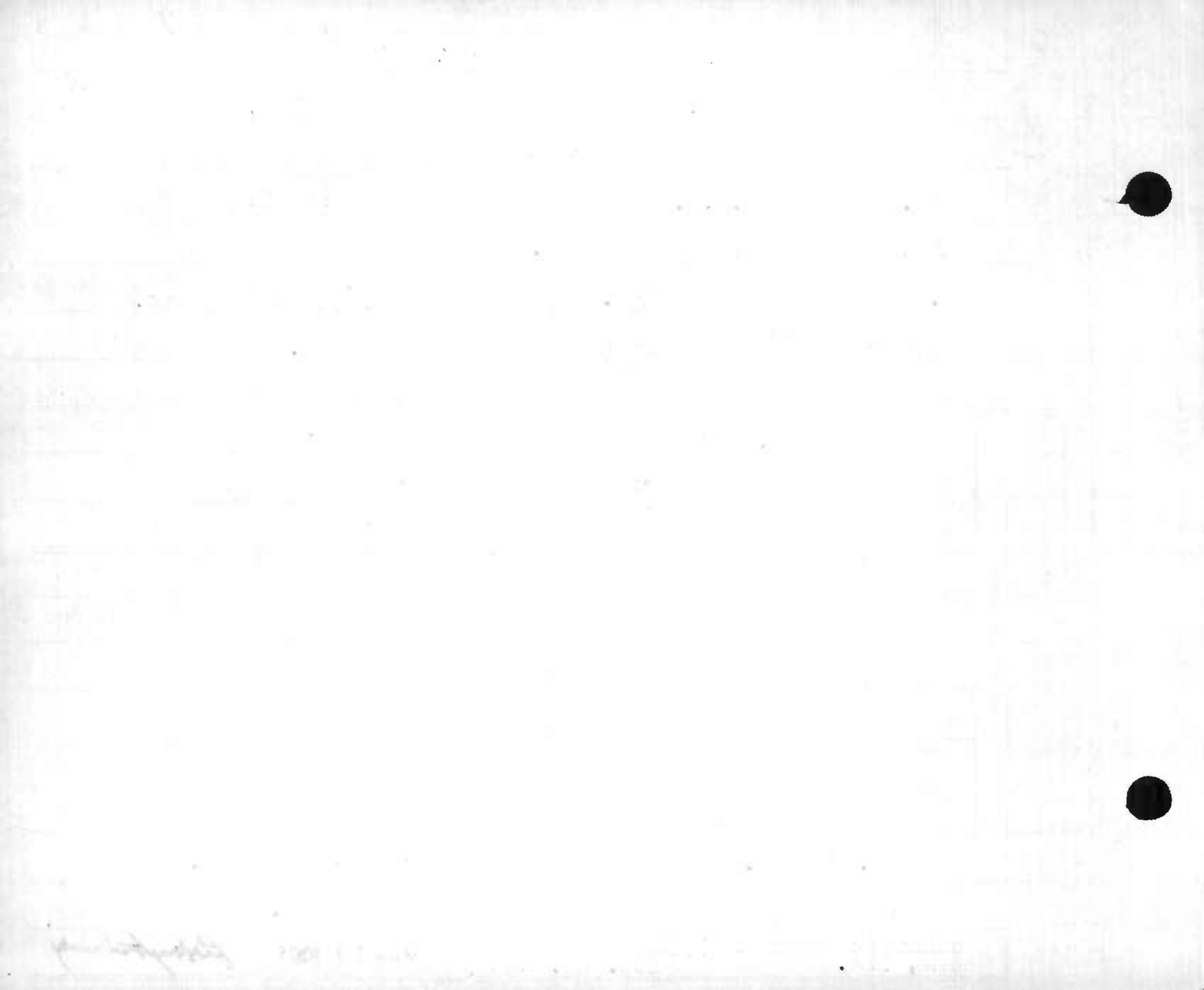
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                   | REG. NO.<br>8107014   |  |
|--|--|--|--|---|--|--|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ruth E. Green   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 6, 1981                                    |  |  | 2b. HOUR<br>8:15 A.M.             |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Apr 28 1913  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | 7. IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3654 Lyndale Ave. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |  |   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Green  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Emma V. Webb                           |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |  |  | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS<br>Esther Denisio (sister) same address                        |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>0000 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) acute coronary<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from NOV-8 1980, to 2/5 1981, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |                                   |   |  |
| 22b. SIGNATURE<br>Dr. Elmo M. Gayoso   |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br>3/6/81   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Elmo M. Gayoso  |  |  |  | 22e. ADDRESS<br>5411 Old Frederick Rd.  |  |  |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/9/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn  |  | 23d. LOCATION<br>BALTO.  |  | COUNTY<br>BALTO.   |                                   | STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>Schlunke Funeral Home, Inc.  |  |  |  | 3331 Brehms Lane<br>Balto. Md. 21213  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                                   |   |  |





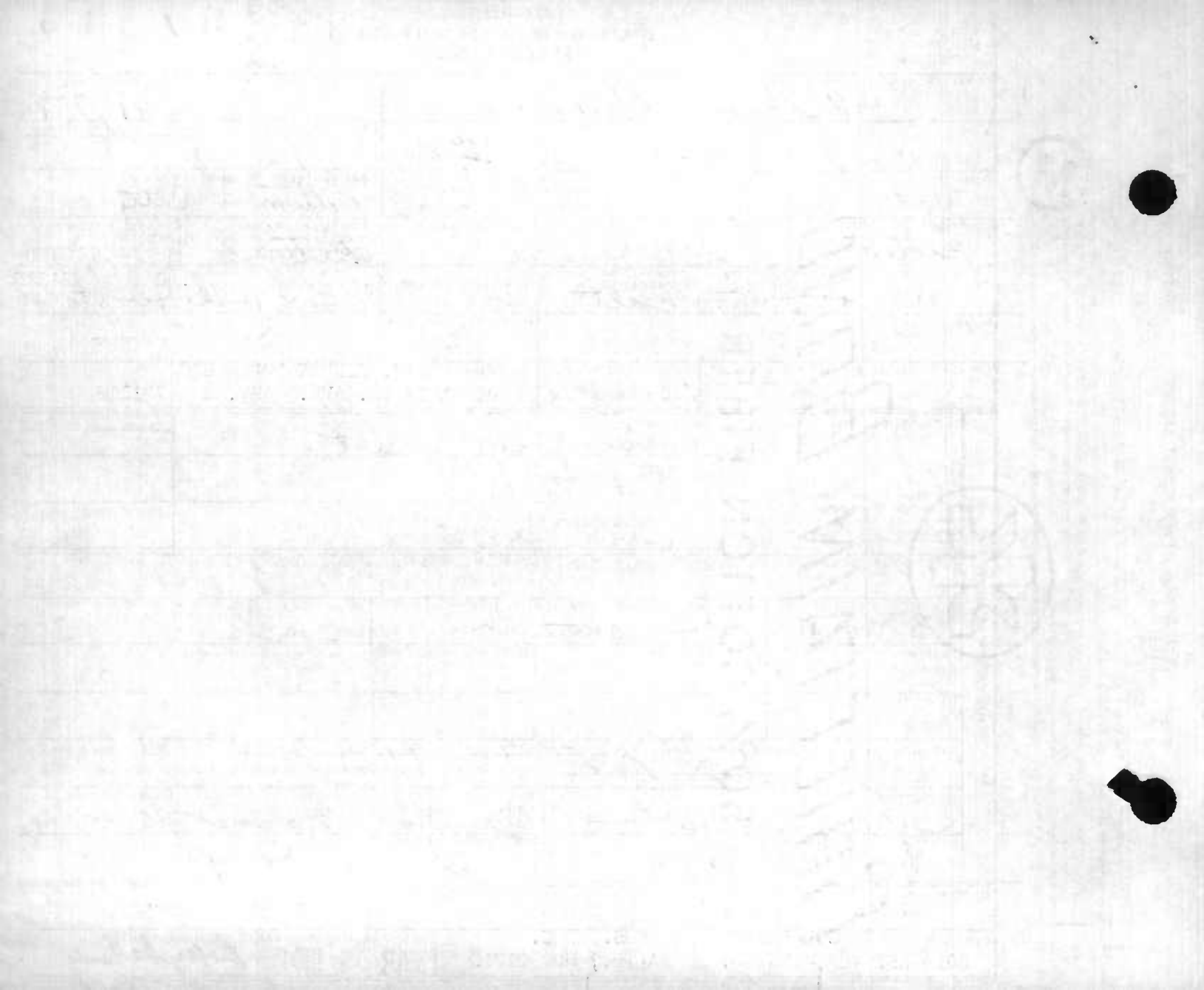
TO HOSPITAL OR FUNERAL HOME: This certificate must be retained by the hospital or funeral home for 24 hours after death. Page 4 may be retained by the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |  | 8 1 0 7 0 1 5   |   |
|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR  |   |   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>A. Abraham Greenberg</b>  |   |   | 2a. DATE OF DEATH MONTH <b>3</b> DAY <b>20</b> YEAR <b>81</b>                                |   | 2b. HOUR <b>7:40 PM</b>   |
| 3. SEX <b>MALE</b>  | 4. RACE <b>CAUCASIAN</b>  | 5. DATE OF BIRTH MONTH <b>10</b> DAY <b>15</b> YEAR <b>04</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |   | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |   |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai</b> | 12. USUAL OCCUPATION (PERMANENT OR WORKING LIFE) <b>TAILOR</b>  | 12b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>                                       |   |   |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Balt</b>   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <b>APT. C 6508 Park Heights ave.</b> #21215                   |   |
| 14. FATHER'S NAME FIRST <b>CHAIM</b> MIDDLE <b></b> LAST <b>GREENBERG</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST <b>ADELE</b> MIDDLE <b></b> LAST <b>UNKNOWN</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |   | 16b. SOCIAL SECURITY NO. <b>216-32-8432</b>   |  | 17. INFORMANT <b>MRS. JENNIE GREENBERG</b>  |   |
|   |   |   |  | 6508 PARK HTS. AVE., APT. C #21215  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmo arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Vent. tach</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Severe ASCVD</b>  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |   |   |  |   |   |
| 19a. DATE OF OPERATION <b>3-20-81</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA stomach</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)          |  |   |   |
| 21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-19</b> 19 <b>81</b> , to <b>3-20</b> 19 <b>81</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>3-20</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE <b>M. Kohn MD</b>  |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>3-20-81</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Kohn MD</b>   |   | 22e. ADDRESS <b>Sinai Hosp.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |   | 23b. DATE <b>3/22/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH JACOB</b>                              |   |
| 23d. LOCATION <b>FINKSBURG</b>  |   | 23e. COUNTY <b>CARROLL</b>  |  | 23f. STATE <b>MD</b>  |   |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME <b>6010 REISTERSTOWN RD.</b> ADDRESS <b>BALTO., MD 21215</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>  |

MEDICAL CERTIFICATION

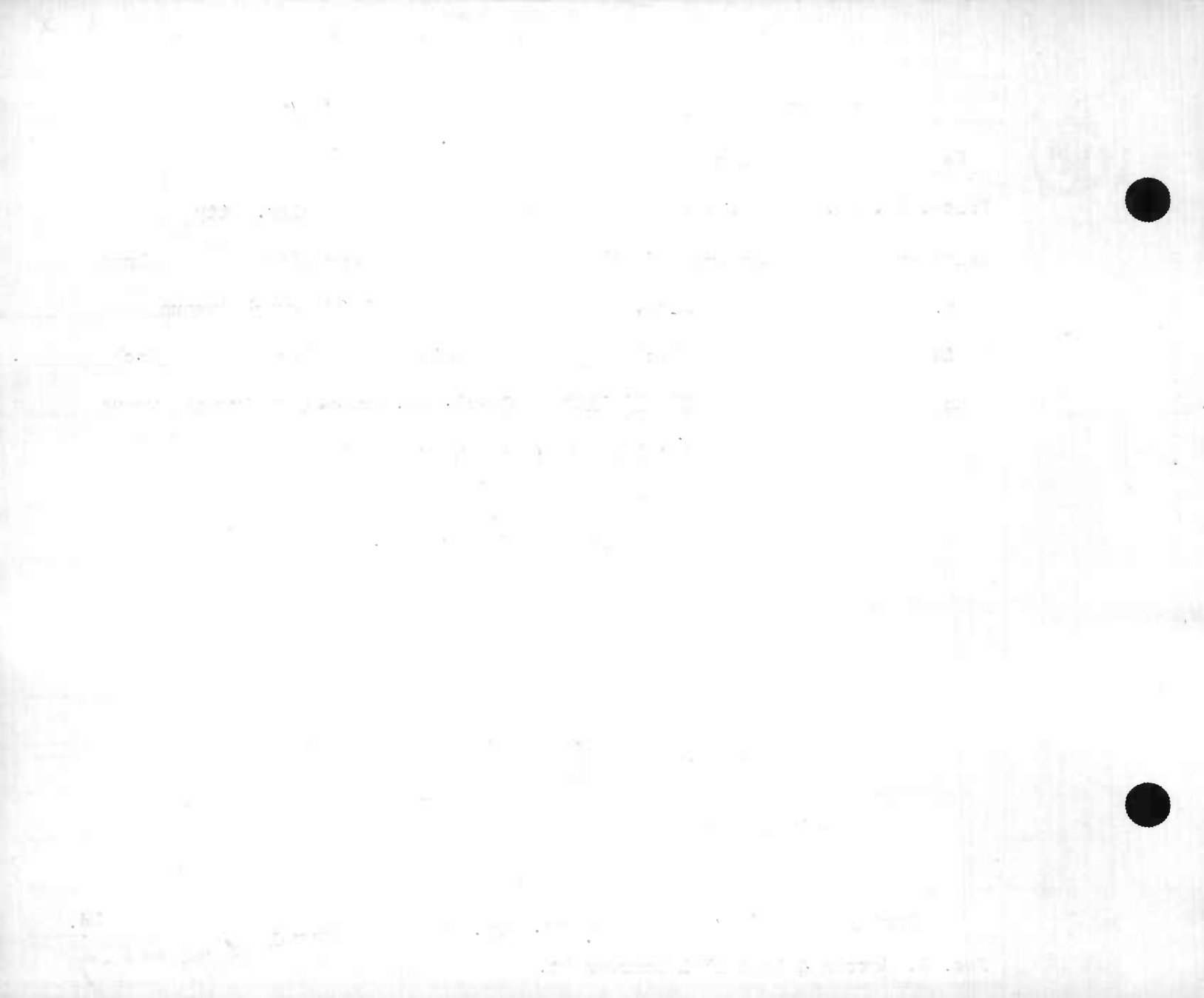


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8 1 0 7 0 1 6  |  |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>LORRAINE P. GREENE</b>   |   |   | 2a. DATE OF DEATH<br><b>3/21/81</b>   |  | 2b. HOUR<br><b>M</b>   |
| 3 SEX<br><b>Fe</b>  | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>3</b> YEAR <b>1912</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Co. Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran (DOA)</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1825 Arunah Avenue</b>                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Lewis</b> MIDDLE <b></b> LAST <b>Pack</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sadie</b> MIDDLE <b>Day</b> LAST <b>Pack</b>               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220 14 7142</b>  |   | 17. INFORMANT<br><b>Gloria Lee Greene</b> ADDRESS <b>1825 Arunah Avenue</b>    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Myocardial infarction + arteriosclerosis</b><br>(c) <b>Cardiovascular disease</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/78</b> 19____, to <b>3/21/81</b> 19____, that (I) (we) lost saw the deceased alive on <b>3/21/81</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |   |   |   |  |  |
| 22b. SIGNATURE<br><b>J. Shorphy M.D.</b>  |   |   | DEGREE<br><b>MD.</b>  |  | 22c. DATE SIGNED<br><b>3/24/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. BOROFISKY</b>  |   |   | 22e. ADDRESS<br><b>601 N. Monroe St 21217</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/26/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat. Mem. Pk</b>                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jas. A. Morton &amp; Sons</b>  |   | ADDRESS<br><b>1701 Laurens St.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Laurel</b>                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| Item 19b G554 4/15/81 dad<br>1- STATE REGISTRAR<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH<br>REG. NO. 8107017  |  |   |  |   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLORENCE C. GREENWELL  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-15-81                                       |  |   |  | 2b. HOUR<br>4:25 AM                                   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 17, 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                        |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, MD.                               |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home & Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House wife       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>home   |  |   |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore City  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br>521 North Bouldin St.          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Southern Ridgell  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Dolan                         |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>578-10-5388   |  | 17. INFORMANT<br>ADDRESS<br>HB Clarence L. Greenwell Same as 13e.                    |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>5520</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIO INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>_____ |  |
| 19a. DATE OF OPERATION<br>3-12-81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Incarcerated femoral hernia</b><br><b>INTRAVENOUS-FEMAL-HERNIA</b>           |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>_____   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>3-11</b> 19 <b>81</b> , to <b>3-15</b> 19 <b>81</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>3-15</b> 19 <b>81</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>H. Sif...</i>  |  |   |  |   |  | DEGREE<br><b>MD.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-15-81                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. X M. L. BIJPURIA, MD.  |  |   |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MD. 21231  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/18/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Michaels Cem.   |  | 23d. LOCATION<br>CITY OR TOWN<br>Ridge   |  | COUNTY<br>St. Mary's  |  | STATE<br>Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W. Clarke Mattingley  |  |   |  |   |  | ADDRESS<br>Leonardtown, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>R. J. ...</i>        |  |

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1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
|---|--|--|--|---|--|---|--|---------------------|--|-------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH             |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| IRVIN   |  |  |  |   |  | GREENWOOD   |  | 03                  |  | 24                |  | 81    |  |      |  | 1:33 PM  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7 IF UNDER 1 YEAR   |  | 8 IF UNDER 24 HRS |  |       |  |      |  |          |  |
| Male  |  | Black  |  | 7 10 97   |  | 83  |  | MONTHS              |  | DAYS              |  | HOURS |  | MIN. |  |          |  |
| 7a BIRTHPLACE (STATE OR COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                     |  |                   |  |       |  |      |  |          |  |
| MD  |  | USA  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Baltimore City, MD  |  |                     |  |                   |  |       |  |      |  |          |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |                     |  |                   |  |       |  |      |  |          |  |
| Baltimore   |  | Provident Hosp   |  | Retiree   |  | Hospital  |  |                     |  |                   |  |       |  |      |  |          |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                   |  |       |  |      |  |          |  |
| MD  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 512 N. Fremont Ave  |  |                   |  |       |  |      |  |          |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| William Greenwood   |  | HARRISON BRADY   |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT  |  | ADDRESS   |  |                     |  |                   |  |       |  |      |  |          |  |
| NO  |  | 220 05 5775  |  | Joseph Greenwood  |  | 512 N. Fremont Ave  |  |                     |  |                   |  |       |  |      |  |          |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                     |  |                   |  |       |  |      |  |          |  |
| 4599  |  | Coronary Artery  |  | Myocardial Infarction   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
|   |  |  |  | Pericardial Failure   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | Sepsis; Severe Vascular Comp. & Forebrain  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY   |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |  |                     |  |                   |  |       |  |      |  |          |  |
| 3/18/81   |  | Severe Vascular Comp. & Forebrain  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                     |  |                   |  |       |  |      |  |          |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
|   |  |  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
|   |  |  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 22a I certify that (I) (this hospital) attended the deceased from 5/10/81 to 3/24/81, that (I) (we) saw the deceased alive on 3/24/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 22b SIGNATURE   |  | DEGREE   |  | 22c DATE SIGNED   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| Ronald D. Miles, M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 3/24/81   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS  |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| Ronald D. Miles, M.D.   |  | Provident Hospital   |  |   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |                     |  |                   |  |       |  |      |  |          |  |
| Burial  |  | 3/24/81  |  | Mt Airy   |  | Baltimore MD  |  |                     |  |                   |  |       |  |      |  |          |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |
| Manhattan & Hager 6387 91/1000 84   |  | MAR 24 1981  |  | F. J. Kelly   |  |   |  |                     |  |                   |  |       |  |      |  |          |  |







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 1 9

1- FOR  
STATE  
REGISTRAR

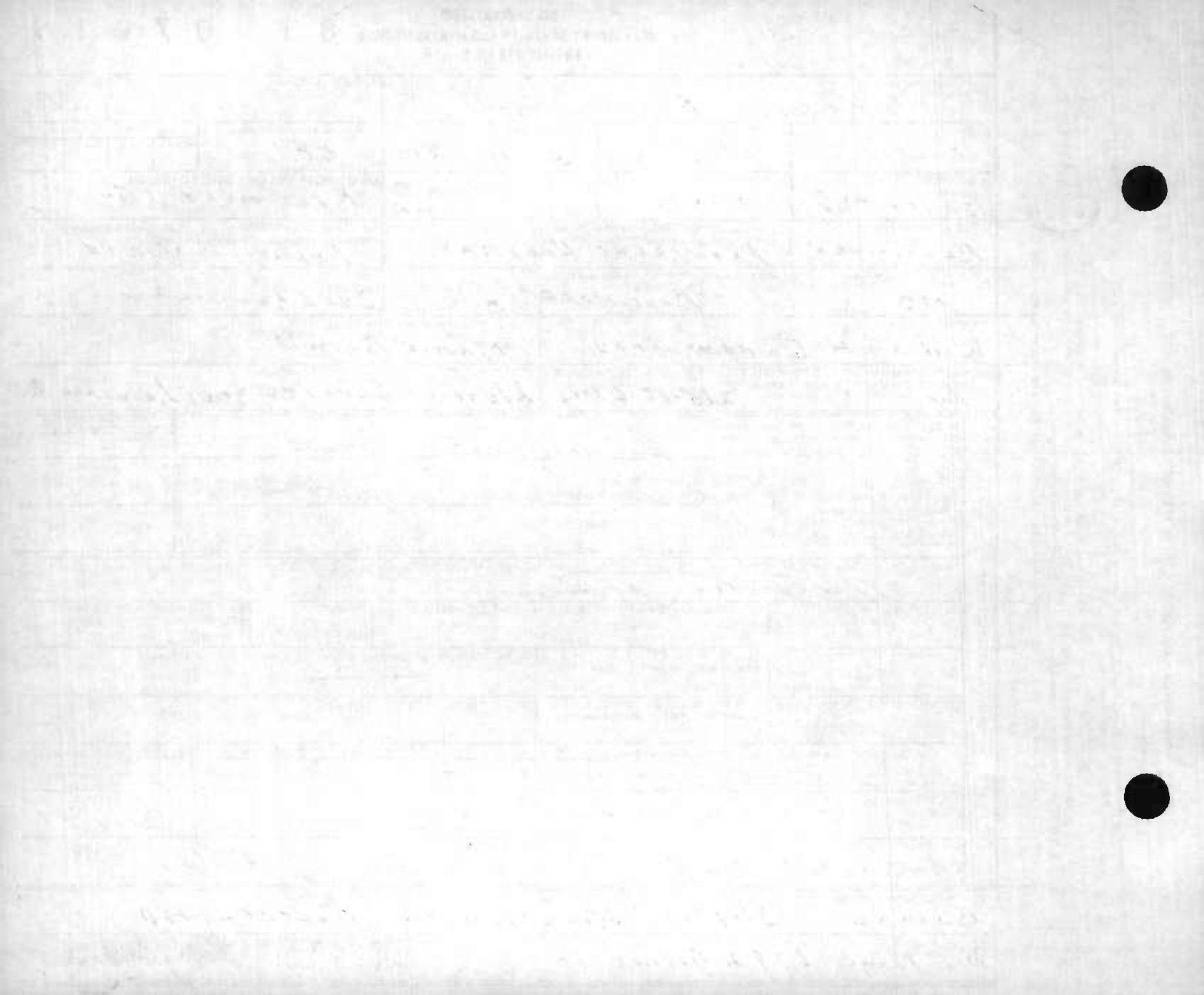
REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Edma P. Furwood</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 14 81</i>   |   | 2b. HOUR<br><i>1030 P.M.</i>   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>5 11 20</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS.                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. MD</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Providence Hospital</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Practitioner</i> | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Nurse</i>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |   |  |
| 13a. STATE<br><i>MD</i>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>3008 Lawina Rd</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William H. Greenwood</i>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mamie Brown</i>                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>215-18-6341</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Kennon Snorren 3008 Lawina Rd</i>                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coronary arterial accident</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>Metabolic disorders</i>  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>3/16</i> , 19 <i>81</i> , to <i>3/19</i> , 19 <i>81</i> , that (1) (we) lost<br>saw the deceased alive on <i>3/19</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) (did) (did not) view the body after death.                         |   |   |   |   |  |
| 22b. SIGNATURE<br><i>L. E. Ruffier MD</i>  |   | DEGREE  |   | 22c. DATE SIGNED<br><i>3/14/81</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>John E. Ruffier</i>  |   | 22e. ADDRESS<br><i>2400 Liberty Heights.</i>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>3/18/81</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Kingdom. PK</i>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. MD</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Mr. Hayes 635 N. G. / on St</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 16 1981</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Released As Non-Med per Dr. Husknecht

DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the attending physician has signed the death certificate, the funeral director should be notified. The funeral director should be detached for use as the burial permit. Then, the funeral director should file the death certificate with the State Dept. of Health and Mental Hygiene prior to burial. Caution: The funeral director should not sign the death certificate. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic cause, the death certificate should be completed in duplicate.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 2 0

|   |  |   |  |
|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>Robert R. Gregory  |  | MONTH DAY YEAR<br>March 11, 1981  |  |
| 3. SEX<br>Male  |  | 2b. HOUR<br>04:14pm   |  |
| 4. RACE<br>Black  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 24 04   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MINS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)<br>Unknown  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)<br>Unknown   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213-07-3212   |  |
| 17. INFORMANT<br>Marjorie Gregory   |  | ADDRESS<br>Park Ave. 1016 N. Patterson  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart disease of unknown etiology</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4275  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |
| 19a. DATE OF OPERATION<br>_____   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19<br>21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> 19 <u>81</u> , to <u>3-11</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-11</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |
| 22b. SIGNATURE<br><u>Hausknecht MD</u>  |  | 22c. DATE SIGNED<br>3-11-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAUSKNECHT, JHH  |  | 22e. ADDRESS<br>601 N BROADWAY 21205  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>3/16/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>Baltimore CITY OR TOWN COUNTY MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH F/H INC. 1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Fitzroy</u>  |  |   |  |

MEDICAL CERTIFICATION

0804

83

CH-EP 810-1  
MARION V. JONES  
AGE 40  
CCNY

2002

10  
33  
100  
1  
7  
3  
5  
30  
2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

2037  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH           |  | KNOWN<br>ESTI-<br>MATED        |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| Hance   |         | Lawson   |  | Griffin, Jr   |  |   |  | 3                                    |  | 17                             |  | 19    |  | 81  |  |      |  |          |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                     |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR |  |
| male  | black   | 11 25 40   |  | 40 YRS.   |  |   |  |                                      |  | 3                              |  | 17    |  | 19  |  | 81   |  | 11 49    |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                |  |       |  |     |  |      |  |          |  |
| Somerset Co. Md   |         | U.S.A  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City                       |  |                                |  |       |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| Baltimore   |         | 1600 Hilton Parkway  |  | Computer Programmer   |  | Insurance   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |                                |  |       |  |     |  |      |  |          |  |
| Md  |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3717 W. Franklin Street              |  |                                |  |       |  |     |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| Hance   |         | Lawson   |  | Griffin Sr  |  | Rita  |  | (NMI)                                |  | young                          |  |       |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| No  |         | 217-42-5529  |  | Mrs. Josie Griffin  |  | 3717 W. Franklin St   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:  |         | IMMEDIATE CAUSE (a):   |  | Craneo-cerebral injury  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 8150  |         | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.  |         | (b):   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
|   |         | (c):   |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | objects   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 11:40 PM 3/17/81  |         | driver in truck in collision with fixed  |  |   |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY                               |  | STATE                          |  |       |  |     |  |      |  |          |  |
| roadway   |         | 1600 Hilton Parkway, Baltimore   |  |   |  |   |  |                                      |  | MD                             |  |       |  |     |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | TITLE (SPECIFY)<br>Assistant   |  | DATE SIGNED   |  | 3/18/81   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| ACTUAL<br>SIGNATURE   |         | M.D.   |  | MEDICAL EXAMINER  |  |   |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | Hormez R. Guard, MD  |  | ADDRESS   |  | 111 Penn Street, Baltimore, MD 21201                                |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY                               |  | STATE                          |  |       |  |     |  |      |  |          |  |
| Burial  |         | 3/23/81  |  | Cedar Hill Cem.   |  | Glen Burnie   |  |                                      |  | MD                             |  |       |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |
| Joseph D. Russ  |         | 2222 W. North Ave  |  | MAR 20 1981   |  | F. J. Halburdy  |  |                                      |  |                                |  |       |  |     |  |      |  |          |  |

1901 C S RAM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 0 2 2  
CERTIFICATE OF DEATH

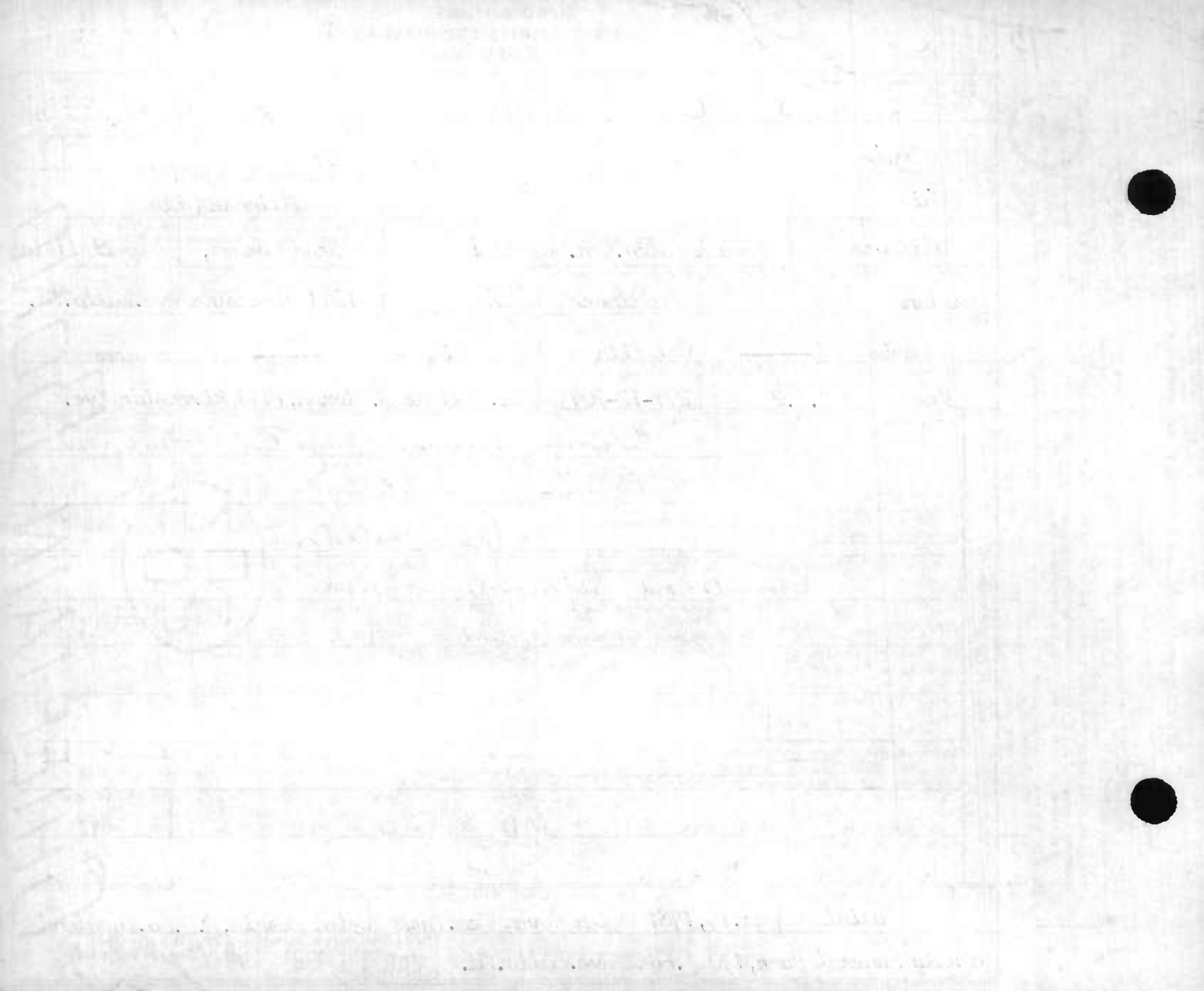
|  |   |  |  |
|--|---|--|--|
| 1. FOR STATE REGISTRAR   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond L. Griffith</b>   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>03/15/81</b> 2b. HOUR <b>9:30 AM</b>                               |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>Caucasian</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 24 17</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. Gen. Hospital</b>                    | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR OR MOST OF WORKING LIFE) <b>Iron Worker</b>  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Ship Building</b>  |  |  |
| 13a. STATE <b>Maryland</b>   | 13b. COUNTY   | 13c. CITY OR TOWN <b>Baltimore</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Lewis ----- Griffith</b>  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vingie ----- Bowman</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   | 16b. SOCIAL SECURITY NO. <b>W.W.2 271-12-7043</b>   | 17. INFORMANT ADDRESS <b>Mrs. Darlene M. Bloxom, 1430 Riverside Ave.</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema + congestion, bilateral, massive</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma right lower lobe with</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>multiple metastases</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis, severe</b>   |   |  |  |
| 19a. DATE OF OPERATION <b>2/27/81</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b> Dx of tumor, removal of fluid</b>  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11/81</b> , 19 <b>81</b> , to <b>3/15</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |   |  |  |
| 22b. SIGNATURE <b>Maureen L. Durkin</b>  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED <b>3/15/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAUREEN L. DURKIN</b>   | 22e. ADDRESS <b>SBGH, 3001 S. Hanover Street, Baltimore</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  | 23b. DATE <b>Mar. 19, 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie, A. Co. Maryland</b>  |
| 24. FUNERAL DIRECTOR <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1981</b>   | 25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

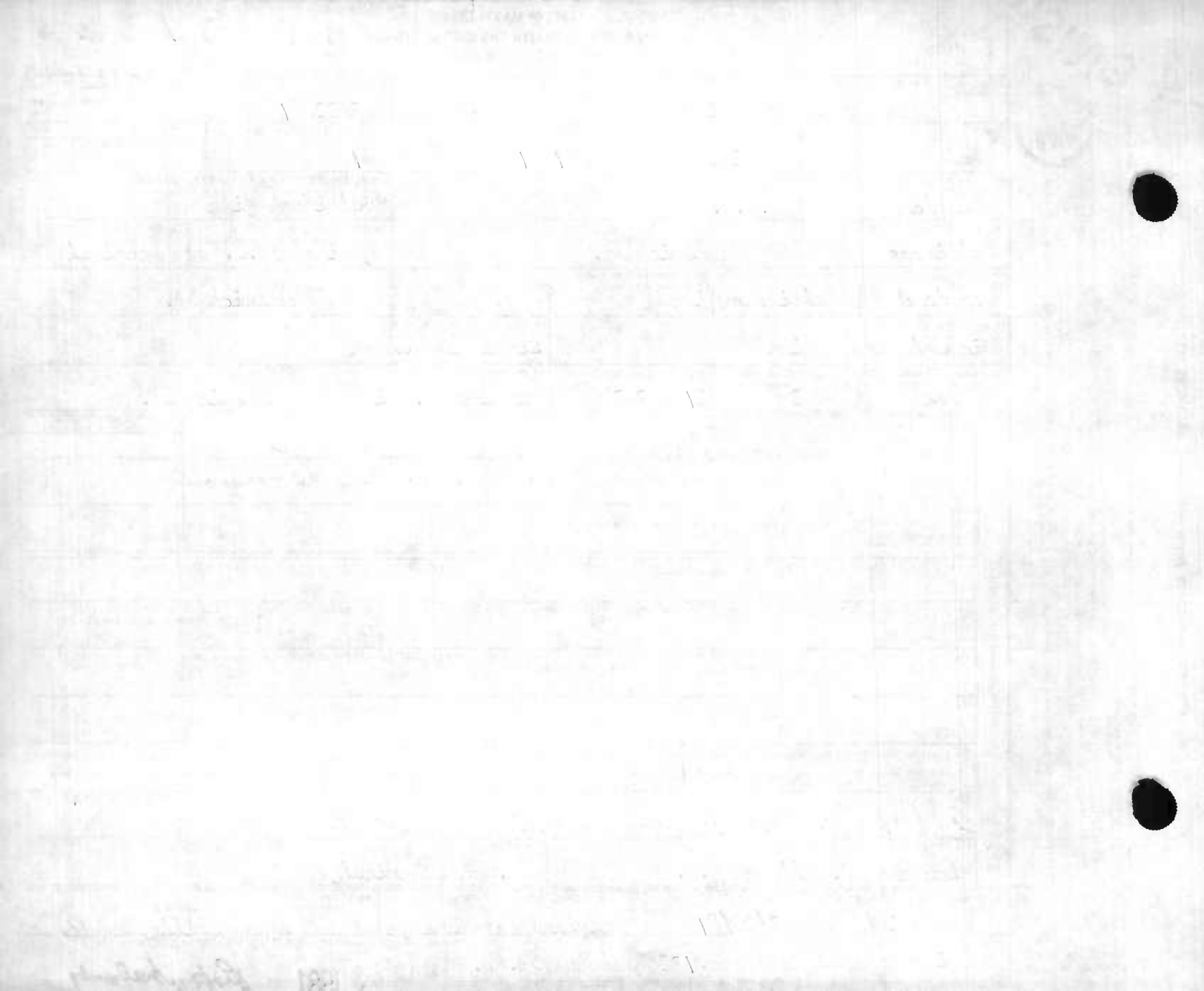
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 2 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |   |  |   |  |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Herbert Le Roy Grimm</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3/22/81</i>                        |   |   | 2b. HOUR<br>M<br><i>AM</i>   |   |  |   |  |
| 3 SEX<br><i>Male</i>   |  | 4 RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7/18/19</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>505 Brunswick St.</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Engineer/U.S. Gov</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Teckinal</i>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>City</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>505 Brunswick St.</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Michael Jacob Grimm</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Linda Mae Palmer</i>     |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><i>215-03-3406</i> |   | 17. INFORMANT<br>ADDRESS<br><i>Margaret R. Grimm 505 Brunswick St.</i>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>with cerebral metastases</i><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>12-18-78</i> , 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <i>3-4-81</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Laurence Gallagher MD</i><br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Laurence R. Gallagher M.D.</i>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22e. ADDRESS<br><i>St. Agnes Medical Ctr.</i>  |  |   |  |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>3/26/81</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Maryland Veterans Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Crownsville Maryland</i>                       |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>Ambrose Funeral Home, Inc. 1328 Sulphur Sp. Rd.</i>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 23 1981</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert H. Brady</i>   |   |  |



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | 8 1 0 7 0 2 4   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |  |  |  | REG. NO.  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARJORIE</b>   |  |  | FIRST<br><b>GRIVER</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 20 81</b>                                |  |   | 2b HOUR<br><b>11:00 AM</b>                           |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 1, 1913</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |   | 7a UNDER 1 YEAR<br>MONTHS DAYS<br><b>11 20</b>       |
| 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>                         |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>3602 CLARINTH RD.</b> 21215 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM SALZMAN</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE MORRIS</b> |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-05-0912</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>MRS. CARLA COHEN</b><br><b>9844 BRANCHLEIGH RD., RANDALLSTOWN, MD 21133</b>                                  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>plac. gastro-intest hemorrhage</b> 2 days<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic Ca. of pancreas</b> 1 yr<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 hr</b> |  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a I certify that (I) (we) attended the deceased from <b>Aug 1, 1978</b> to <b>Mar 20, 1981</b> , that (I) (we) last saw the deceased alive on <b>Mar 20, 1981</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><b>Jonas H. Cohen</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c DATE SIGNED<br><b>3/20/81</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JONAS H. COHEN</b>   |  | 22e ADDRESS<br><b>6701 Park Heights Ave.</b>   |  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b DATE<br><b>3/22/81</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>HAR SINAI</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>OWINGS MILLS BALTO. MD</b>                     |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |   | 25b REGISTRAR'S SIGNATURE<br><b>Hofsky &amp; Brady</b>   |   |  |



12/11  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                              |  |   |                                      |                                      |                                      |  |                 | 8   | 1                                 | 0                           | 7        | 0   | 2 | 5                   |  |
|---|--|------------------------------|--|---|--------------------------------------|--------------------------------------|--------------------------------------|--|-----------------|---|-----------------------------------|-----------------------------|----------|---|---|---------------------|--|
| 1- FOR STATE REGISTRAR  |  |                              |  |   |                                      |                                      |                                      |  |                 | CERTIFICATE OF DEATH  |                                   |                             |          |   |   |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |                              |  |   |                                      |                                      |                                      |  |                 | 2a. DATE OF DEATH   |                                   |                             | 2b. HOUR |   |   |                     |  |
| FIRST MIDDLE LAST<br>VERNON - GROB  |  |                              |  |   |                                      |                                      |                                      |  |                 | MONTH DAY YEAR<br>MARCH 31, 1981  |                                   |                             | 10:12A   |   |   |                     |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                      |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS                   |                             |          |   |   |                     |  |
| Male  |  | White                        |  | MONTH DAY YEAR<br>June 25, 1922   |                                      |                                      | 58                                   |  | MONTHS DAYS     |   | HOURS MIN.                        |                             |          |   |   |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                 |   |                                   |                             |          |   |   |                     |  |
| Maryland  |  | United States                |  |   |                                      |                                      | Baltimore City MD.                   |  |                 |   |                                   |                             |          |   |   |                     |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                                      |                                      |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                 |   | 12b. KIND OF BUSINESS OR INDUSTRY |                             |          |   |   |                     |  |
| Baltimore   |  |                              |  | Church Hospital Corporation   |                                      |                                      |                                      | Merchant-seaman  |                 |   | Maritime                          |                             |          |   |   |                     |  |
| 13a. STATE  |  |                              |  |   |                                      |                                      |                                      |  |                 | 13b. COUNTY   |                                   | 13c. CITY OR TOWN           |          | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS |  |
| Maryland  |  |                              |  |   |                                      |                                      |                                      |  |                 | -   |                                   | Baltimore                   |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 239 S. Ann St.      |  |
| 14. FATHER'S NAME   |  |                              |  |   | 15. MOTHER'S MAIDEN NAME             |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| FIRST MIDDLE LAST<br>Steve - Grob   |  |                              |  |   | FIRST MIDDLE LAST<br>Minnie - Herman |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              |  | 16b. SOCIAL SECURITY NO   |                                      | 17. INFORMANT ADDRESS                |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| Yes   |  |                              |  | W.W.II  |                                      | 213-14-3224 Rita Grob 239 S. Ann St. |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |                              |  |   |                                      |                                      |                                      |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                   |                             |          |   |   |                     |  |
| IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>   |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| 4960 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) COR PULMONALE  |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE   |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      |                                      |                                      | 20a. AUTOPSY?  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                      |                                   |                             |          |   |   |                     |  |
| 3-31-81   |  |                              |  | CHRONIC OBSTRUCTIVE PULMONARY DISEASE   |                                      |                                      |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                            |                                   |                             |          |   |   |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                      |                                      |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                 |   |                                   |                             |          |   |   |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      |                                      |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                 |   |                                   |                             |          |   |   |                     |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>MARCH 21, 1981</u> , to <u>MARCH 31, 1981</u> , that (I) (we) last saw the deceased alive on <u>MARCH 31, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |                                      |                                      |                                      |  |                 |   |                                   |                             |          |   |   |                     |  |
| 22b. SIGNATURE<br>A. F. Nazemi M.D.   |  |                              |  |   |                                      |                                      |                                      |  |                 | DEGREE  |                                   | 22c. DATE SIGNED<br>3-31-81 |          |   |   |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. F. NAZEMI, M.D.   |  |                              |  |   |                                      |                                      |                                      |  |                 | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD 21231 |                                   |                             |          |   |   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              |  | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |                                      |  |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |                                   |                             |          |   |   |                     |  |
| Burial  |  |                              |  | April 3, 81   |                                      | Baltimore National Cem.              |                                      |  |                 | Baltimore - , Maryland  |                                   |                             |          |   |   |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler Inc. 1901 Eastern Ave.   |  |                              |  |   |                                      |                                      |                                      |  |                 | 25a. DATE REC'D. BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE  |          |   |   |                     |  |
|   |  |                              |  |   |                                      |                                      |                                      |  |                 | APR 01 1981   |                                   | [Signature]                 |          |   |   |                     |  |

1994

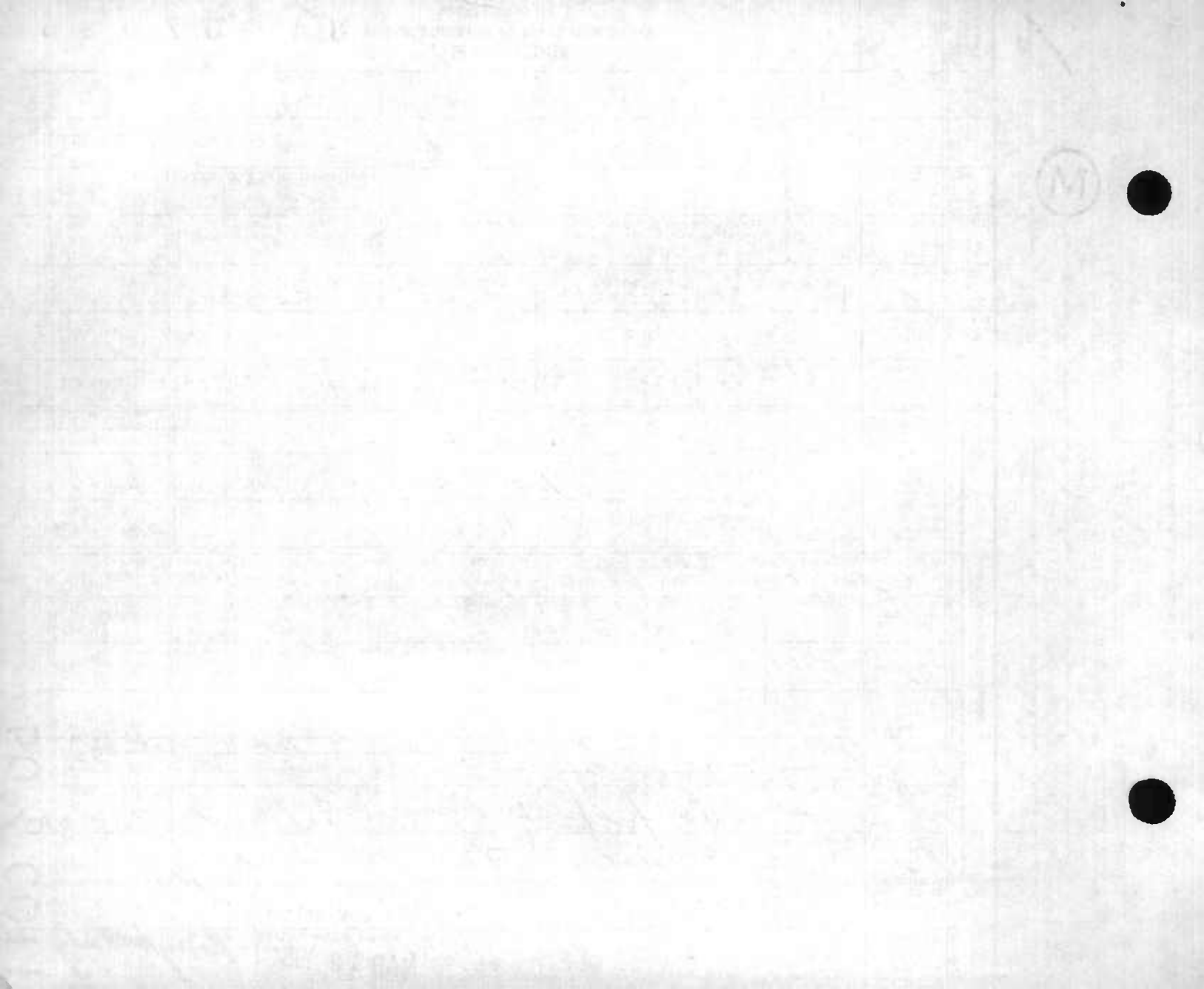
1682 JOURNAL OF CLIMATE

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|--|--|--|--|---|---------------------------------------|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |                                       |   |   |   |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |                                       |   |   |   |   |  |
| REG. NO.   |  |  |  |   |                                       |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   | 2a. DATE OF DEATH                     |   |   |   |   |  |
| FIRST MIDDLE LAST<br>Eliza A. Gross  |  |  |  |   | MONTH DAY YEAR HOUR<br>March 16, 1981 |   |   |   |   |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |                                       | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |   | 7b. HOUR  |   |  |
| Female   |  | Negro  |  | MONTH DAY YEAR<br>12 10 93  |                                       | 87  |   | M   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |   |   |  |
| Maryland   |  | USA  |  |   |                                       | Baltimore City MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                       |   |   |   |   |  |
| Baltimore  |  | 423 Scott Street   |  |   |                                       |   |   |   |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY     |   |   |   |   |  |
|  |  |  |  |   |                                       |   |   |   |   |  |
| 13a. STATE   |  |  |  |   | 13b. COUNTY                           |   | 13c. CITY OR TOWN                       |   | 13d. INSIDE CITY LIMITS?  |  |
| MD   |  |  |  |   |                                       |   | Baltimore                               |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |  |   | 15. MOTHER'S MAIDEN NAME              |   |   |   |   |  |
| MCCULLUM   |  |  |  |   | REBECCA                               |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   | 16b. SOCIAL SECURITY NO.              |   | 17. INFORMANT ADDRESS                   |   |   |  |
|  |  |  |  |   | 217-03-0633                           |   | Sarah E. Brunson 423 Scott Street       |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u>   |  |  |  |   |                                       |   |   |   |   |  |
| 4414 DUE TO, OR AS A CONSEQUENCE OF <u>AORTIC ABDOMINAL ANEURYSM</u> YEARS.  |  |  |  |   |                                       |   |   |   |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSION</u> MANY YEARS  |  |  |  |   |                                       |   |   |   |   |  |
| (c)  |  |  |  |   |                                       |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CONGESTIVE HEART FAILURE, AORTIC STENOSIS + INSUFFICIENCY, THORACIC AORTIC ANEURYSM</u>   |  |  |  |   |                                       |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                                       | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |  |
| 0  |  | 0  |  |   |                                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                       |   |   |   |   |  |
|  |  | 19   |  |   |                                       |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |                                       |   |   |   |   |  |
|  |  |  |  |   |                                       |   |   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>AUGUST</u> 19 <u>80</u> , to <u>MARCH</u> 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>MARCH 2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (they) (did not) view the body after death. |  |  |  |   |                                       |   |   |   |   |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE                                |   |   | 22c. DATE SIGNED  |   |  |
| <u>Scott Douglas Friedman</u>  |  |  |  |   | MD                                    |   |   | 3/17/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | 22e. ADDRESS                          |   |   |   |   |  |
| SCOTT DOUGLAS FRIEDMAN   |  |  |  |   | 72 S. Green St. UNIV OF MD HOSPITAL   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                       |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |   |  |
| Burial   |  | 3/21/81  |  | Arbutus Mem. Park   |                                       |   | Arbutus MD.                             |   |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR         |   | 25b. REGISTRAR'S SIGNATURE              |   |   |  |
| Wm. C. March F/H 1101 E. North Ave.  |  |  |  |   | MAR 18 1981                           |   | <u>[Signature]</u>                      |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMM-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 8 1 0 7 0 2 7   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary A. Gross</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 17, 1981</b>                                    |  |  | 2b. HOUR<br><b>3:45A</b> M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 21 1894</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Families</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13e. STREET ADDRESS<br><b>Balto., Md. 21217<br/>501 Dolphin St. Apt. 1315</b>        |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Dennis Gross</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Elizabeth Smith</b>                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-0148</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Balto., Md. 21217<br/>Mrs. Myrtle I. Brooks 501 Dolphin Street</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Accident</b><br><b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>                |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Congestive Heart Failure</b>  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 17 81</b> to <b>March 17 81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 17 81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Craig Mattin</b>   |  |   |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-17-81</b>               |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Craig Mattin, MD.</b>   |  |   |  |   | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-21-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County Maryland</b>       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Herbert E. Nutter Funeral Home</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |

1702 BP 6

MEMO: [illegible]



[Extremely faint, mostly illegible text body consisting of several paragraphs.]

MAR 19 1961

Gray Martin, Mr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |  |
|--|--|--|--|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO. 07028   |   |  |   |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>Ronald Hackett  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>March 16, 1981  |   |  | 2b HOUR<br>9:08AM   |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Negro  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>9 6 44   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                            |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  | 13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |  |  |
| 13a STATE<br>MD  |  | 13b COUNTY   |  | 13c CITY OR TOWN<br>Baltimore  |  | 13d STREET ADDRESS<br>916 N. Wolfe St.  |  |   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Charles Hackett  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dorethea Clarke   |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO<br>N/A  |  | 17 INFORMANT ADDRESS<br>Anrair M. Clay 837 N. Wolfe St.  |  |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Shock Cardiogenic<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Disseminated Intravascular Coagulation<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Intraperitoneal bleed                         |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24°<br>24°<br>28°   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Pocket Hypertension 2° to Cirrhosis   |  |  |  |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION<br>3/15  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Bleeding Umbilical Vein Varix   |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 3/15 19 81, to 3/16 19 81, that (I) (we) lost saw the deceased alive on 3/16 7:08 AM 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |
| 22b SIGNATURE<br>J. P. Jacob   |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c DATE SIGNED<br>3/16/81  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. P. Jacob  |  |  |  |  | 22e ADDRESS<br>J H H   |   |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>3/20/81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.   |  |   | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |   |  |  |
| 24 FUNERAL DIRECTOR NAME<br>Wm. C. March F/H   |  |  |  |  | ADDRESS<br>1101 E. North Ave.  |   | 25a DATE REC'D. BY REGISTRAR<br>MAR 17 1981                |   | 25b REGISTRAR'S SIGNATURE<br>[Signature] |  |

85070

RECEIVED

DATE: 11/11/1951

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

RE: [illegible]

RECORDED

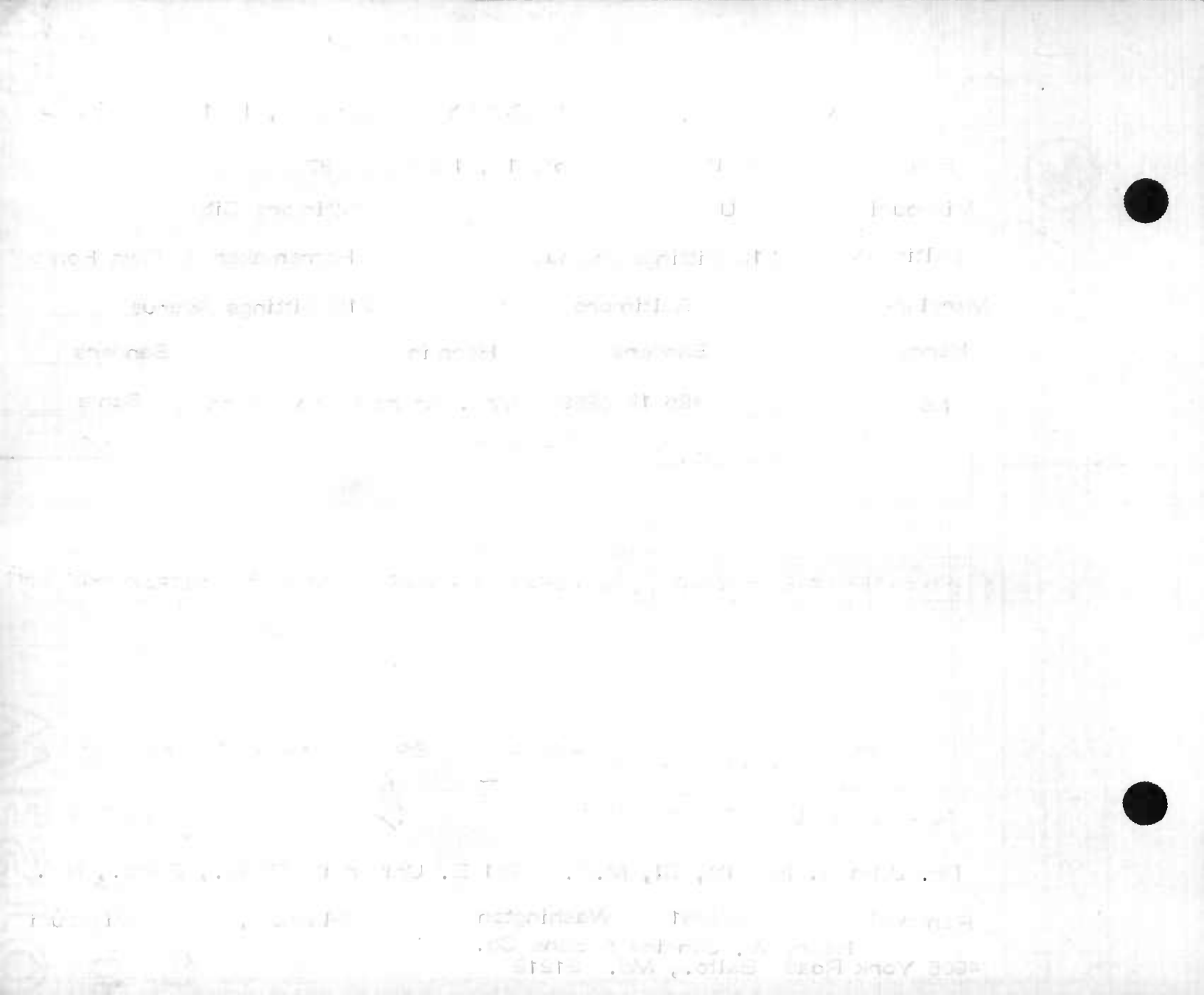
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11/11/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8107029   |  |   |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| LEONA  |  | M.   |  | HACKLEY   |  | March 5, 1981   |  | 12 <sup>30</sup>  |  | AM   |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                                |  |
| Female   |  | White  |  | Sept. 13, 1893  |  | 87 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Missouri   |  | USA  |  |   |  | Baltimore City MD.  |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |
| Baltimore  |  | 210 Gittings Avenue  |  | Homemaker   |  | Own Home  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS  |  |
| Maryland   |  |  |  | Baltimore   |  |   |  | 210 Gittings Avenue   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |   |  |   |  |  |  |
| Henry Sanders  |  | Hermine Sanders  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT  |  | ADDRESS   |  |   |  |  |  |
| No   |  | 496 12 8959  |  | Mrs. Andrew Stevenson   |  | Same  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SYSTEMIC MASTOCYTOSIS</u>  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 MO.</u> |  |
| 7573   |  |  |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE ASCVD, CALCIFIED THYROID, SEVERE OSTEOPOROSIS, CHF</u>  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |
|  |  |  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JAN. 2</u> 19 <u>80</u> , to <u>MARCH 5</u> 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>MARCH 5</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |   |  | 22c. DATE SIGNED  |  |   |  |  |  |
| <u>John A. Nesbitt, III</u>  |  | M.D.   |  |   |  | 3/5/81  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |  |  |
| Dr. John A. Nesbitt, III, M.D.   |  | 201 E. University Pkwy., Balto., Md.   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| Removal  |  | 3/6/81   |  | Washington  |  | Glasgow,  |  |   |  | Missouri   |  |
| 24 FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |
| Henry W. Jenkins & Sons Co.  |  | MAR 5 1981   |  |   |  | <u>Henry W. Jenkins</u>   |  |   |  |  |  |
| 4905 York Road Balto., Md. 21212   |  |  |  |   |  |   |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ELSIE V HAILEY  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 6 81                |  |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 17 20                                 |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.                                     |   |
| 10. CITY OR TOWN OF DEATH<br>BALTO  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV. OF MARYLAND |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.                         |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Assembly line  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eastman Venetian Blinds |  |   |
| 13a. STATE<br>MD  |  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>BALTO                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALBERT H. Robinson  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>MARY E. Matthews |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>229 22 9889  |  | 17. INFORMANT<br>ADDRESS<br>CONDIFF, Pauline Ba Ho, MD                         |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal Failure<br>3030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension assoc c. Maximal Upper GI Bleed<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ALCOHOLISM<br>WERNICKE'S - KORSAKOFF'S SYNDROME |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from March 5, 1981, to March 6, 1981, that (I) (we) last saw the deceased alive on March 6, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |  |  |   |
| 22b. SIGNATURE<br>Andre F. Lipo MD  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>3/6/81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ANDRE F. LIPON   |  | 22e. ADDRESS<br>UNIV. MD HOSP, BALTO, MD   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-8-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Allegheny Memorial Park                  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles L. Stevens Funeral Home, Inc.   |  | ADDRESS<br>1501 E. Fort Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981                                    |   |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Betsy K. K... ..                                 |   |

CHANDLER MATHIAS



13013 1011002002

*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |  |  |   | REG. NO. 07031  |  |
|---|--|-------------------------|--|---|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |                         |  |   |  |   |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert A.W. Hall, Jr</b>   |  |                         |  |   |  |   |  |  |   | 2b. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>3 17 81</b> |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>13</b> YEAR <b>32</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>48</b> YRS.   |  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>          |   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>3</b> DAY <b>17</b> YEAR <b>81</b>                         |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2130 Aiken Street</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Md.</b>  |  |                         | 13b. COUNTY  |   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Albert</b> MIDDLE <b>A.</b> LAST <b>Hall, Sr.</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Edna</b> MIDDLE <b>G.</b> LAST <b>Holt</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-28-6574</b>  |   |  |
| 17. INFORMANT<br>ADDRESS<br><b>Edna G. Hall 2130 Aiken</b>  |  |                         |  |   |  |   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>(b) <b>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</b><br>(c) <b>Head Only</b>   |  |                         |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                         |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> (HO) NO <input type="checkbox"/> |   |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> (Head Only) Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>                               |  |   |  | DATE SIGNED<br><b>3/18/81</b>  |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>            |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>3/25/81</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hampton Nat. Cem.</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampton, Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |                         |  | ADDRESS<br><b>1101 E. North Ave.</b>                              |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

SECRET

CONFIDENTIAL

MAR 2 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 3 2

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rev. William A. Hall  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 18, 1981 |   |  | 2b. HOUR<br>2:25pm   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 26 86   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTRY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br>1213 Harford Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Hall   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Sasser  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-07-8566  |  | 17. INFORMANT ADDRESS<br>Estell Estairir Hodges 919 N. Wolfe  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypotension</u><br>4280 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Explanatory Laparotomy for Small Bowel Obstruction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>Unknown - Years</u><br><u>3 days</u> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Adult Respiratory Distress Syndrome, Massive Transfusions, Acute Tubular Necrosis</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>3-16-81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Small Bowel Obstruction - Complete  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>3-16</u> , 19 <u>81</u> , to <u>3-18</u> , 19 <u>81</u> , that (a) (we) last saw the deceased alive on <u>3-18</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Roger E. Schneider</u> MD   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>3-18-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Roger E. Schneider MD   |  |   |  | 22e. ADDRESS<br>Johns Hopkins Hospital - Baltimore, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/25/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MD. NAT. MEM. PK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM.C. MARCH F/H INC.   |  |   |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981   |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. J. Halbrudy</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The Registrar certifies that the death certificate has been signed by the attending physician and certified by the funeral director. It should be detached for use as the burial-transit permit. Then please remove local copies. Register and Certificate should be filed with the Registrar. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Page 4 may be retained by the hospital or attending physician. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified and get an autopsy.

— 10 —



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |
| REG. NO. 8 1 0 7 0 3 3  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>J. CELESTE B. HAMPTON  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>03 19 89   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 15 1889  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91  |  | 7b. HOUR<br>6:10 M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bn Secours Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>James Biden  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary B. UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>220-44-5672   |  | 17. INFORMANT ADDRESS Balto., Md.<br>Erick S. Larsen 4305 Glenmore Ave. 21206  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) congestive heart failure<br>2500 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) protein-calorie malnutrition<br>DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 wks<br>2 mon<br>10 yrs(?)  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>anemia, ulcerative colitis vs. granulomatous colitis, decubitus ulcers   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) the hospital attended the deceased from March 7, 19 81, to March 19, 19 81, that (1) (was) lost<br>saw the deceased alive on March 19, 19 81, and that in (my) opinion death occurred on the date and hour and from the causes stated   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Stephen R. Smith, MD  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-19-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEPHEN R. SMITH, MD   |  |   |  |   |  | 22e. ADDRESS<br>2000 W. BALTIMORE ST., BALTIMORE 21223   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/23/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Balto. Co. Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981   |  | 25b. THIS DEATH'S NUMBER   |  |



1 PIE



20% COTTON FIBER

100% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their office should remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 3 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JESSE HANEY   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03/26/81                   |   |  | 2b. HOUR<br>2:54p  |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 28 22  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N. CAROLINA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MECHANIC   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>ANDERSON  |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>---  |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEE HANEY  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LULA MAE UNKNOWN |   |  | 13e. STREET ADDRESS<br>CHEVROLET<br>1241 GLYNDON AVENUE, 21223   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>238-22-4871                           |   | 17. INFORMANT<br>ADDRESS<br>FRANCES STULL 319 S. STRICKER ST., 21223                 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>sepsis</i><br>5789<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>status post right hemicolectomy</i><br>(c) <i>gastrointestinal bleeding</i> |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>12 days<br>13 days   |  |
|  |  |   |   |   |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><i>ethanol abuse, hepatic encephalopathy</i> |  |
|  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>3/14/81  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>rectal bleeding   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 3/11, 19 81, to 3/26, 19 81, that (we) lost saw the deceased alive on 3/26, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Mark W. Ratain   |  |   |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/26/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK J. RATAIN  |  |   |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>03-30-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CREST LAWN MEM. GAR.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE HOWARD MD.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   |  |   |   | ADDRESS<br>21229<br>4107 WILKENS AVE.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 1 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                              |   |  |                                    |  |  |  |                  |  |  |
|---|--|------------------------------|---|--|------------------------------------|--|--|--|------------------|--|--|
| <div style="text-align: right;">8107035</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           REG. NO.         </div>  |  |                              |   |  |                                    |  |  |  |                  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST   |  |                                    | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |                  | 2b. HOUR                                     |  |
| Patricia U.   |  |                              | Hanke   |  |                                    | 3 10 81  |  | 5 55   |                  | M  |  |
| 3 SEX   |  | 4 RACE                       |   | 5 DATE OF BIRTH  |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |                  | IF UNDER 24 HRS                              |  |
| F   |  | Cauc                         |   | 12 8 36  |                                    | 44 YRS   |  | MONTHS DAYS  |                  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |                  |  |  |
| Wisconsin   |  | USA                          |   |  |                                    | Baltimore City MD.   |  |  |                  |  |  |
| 10 CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |                  |  |  |
| Balt City   |  |                              | BCRP, University Hosp.  |  |                                    | housewife  |  | own home   |                  |  |  |
| 13a. STATE  |  |                              |   |  |                                    | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |                  |  |  |
| Wisconsin   |  |                              |   |  |                                    | Madison  |  | 508 E. Lakeview  |                  |  |  |
| 14 FATHER'S NAME  |  |                              | 15 MOTHER'S MAIDEN NAME   |  |                                    |  |  |  |                  |  |  |
| FIRST MIDDLE LAST   |  |                              | FIRST MIDDLE LAST   |  |                                    |  |  |  |                  |  |  |
| Ardis   |  |                              | McCauley  |  |                                    | ERMA Cottrill  |  |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |                              | 16b. SOCIAL SECURITY NO.  |  |                                    | 17 INFORMANT ADDRESS   |  |  |                  |  |  |
| No  |  |                              | 387.36.5283   |  |                                    | GUNDERSON FUNERAL HOME, WISC.  |  |  |                  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |   |  |                                    |  |  |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia   |  |                              |   |  |                                    |  |  |  |                  | 3 d.   |  |
| 2050<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |                              |   |  |                                    |  |  |  |                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute myelogenous leukemia   |  |                              |   |  |                                    |  |  |  |                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                              |   |  |                                    |  |  |  |                  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |   |  |                                    |  |  |  |                  |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |  |  |
|   |  |                              |   |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from March 1, 19 81, to 10 March 19 81, that (I) (we) lost saw the deceased alive on 10 March 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |                              |   |  |                                    |  |  |  |                  |  |  |
| 22b. SIGNATURE  |  |                              | DEGREE  |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED |  |  |
| Elizabeth Poplin  |  |                              |   |  |                                    |  |  |  | 10 March 81      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              | 22e. ADDRESS  |  |                                    |  |  |  |                  |  |  |
| Elizabeth Poplin  |  |                              | BCRP 22 S. Greene St Balto  |  |                                    |  |  |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                  |  |  |
| Removal   |  |                              | 3/10/81   |  | Highland Mem. Gard.                |  | Dane Wisc.                                 |  |                  |  |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS  |  |                              |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |                  |  |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |                              |   |  |                                    | MAR 11 1981  |  | [Signature]  |                  |  |  |

1. *[Faint handwritten text, possibly a list or notes]*  
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 100. *[Faint handwritten text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8107036   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>DORIS AMELIA HANNER  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-18-1981  |  |  | 2b. HOUR<br>AM  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-24-1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1300 E. LANVALE STREET |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK- FEDERAL  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>GOVT.                    |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1300 E. LANVALE STREET                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MALCOLM CRAIG   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CAROLINE MC RAE                        |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>779-10-2415  |  | 17. INFORMANT ADDRESS<br>CLEMON HANNER 1300 E. LANVALE STREET   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u><br><u>5728</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 MONTH</u> |  |  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERTENSION</u>   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>12-9-80</u> , 19 <u>80</u> , to <u>12-10-80</u> , 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>12-10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Carlton C. Greene</u>   |  |  |  | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3-21-81</u>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CARLTON C. GREENE   |  |  |  | 22e. ADDRESS<br>M.D. 1501 PENTRIDGE RD  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3-23-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEMORIAL PK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY, MD.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>HERBERT E. NUTTER   |  |  |  | ADDRESS<br>3035-37 W. NORTH AVE   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert H. Brady</u>          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |   |  |  | 8 1 0 7 0 3 7   |  |
|---|--|--|---|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.  |   |  |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>CLINTON HARTWIG HANSON  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>MARCH 26, 1981                  |   |  |  | 2b. HOUR P M<br>8:30 AM   |  |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>October 24, 1911   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |   | 7. IF UNDER 1 YEAR MONTHS DAYS                     |  | 7b. IF UNDER 24 HRS. HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Massachusetts  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3018 Louise Ave. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Draftsman   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Manufacturing |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland  |  |  | 13c. COUNTY   |   | 13d. CITY OR TOWN<br>Baltimore   |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13f. STREET ADDRESS<br>3018 Louise Ave.  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Hartwig Hanson   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Susan Collins   |  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |   | 16b. SOCIAL SECURITY NO.<br>220-12-3746   |  | 17. INFORMANT ADDRESS<br>Donald S. Kelner, Sr. Belair, Maryland  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intermittent cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |   |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>119 minutes |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>5-4</u> 19 <u>72</u> to <u>3-26</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |   |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Frank G. Kuehn</u> MD  |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3-27-81                        |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frank G. Kuehn, M.D.   |  |  |   |   |  | 22e. ADDRESS<br>7600 Osler Drive, Towson, Md. 21204  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>Mar. 30, 1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Parkville, Balto. Co., Md.                           |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md.  |  |  |   |   |  | 24. ADDRESS<br>6500 York Rd.   |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 31 1981        |  |   |  |
| 25. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |   |   |  |  |   |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 3 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>(Ann) Enna May Hanson</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1981</b>                              |   | 2b. HOUR<br><b>10:30PM</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 23, 1903</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Harford Co. Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Factory Worker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hedwin Corp.</b>          |   |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>- - - -</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Evans</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Fae</b>                          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No None</b> |   | 16b. SOCIAL SECURITY NO.<br><b>213-12-2831-4</b>  | 17. INFORMANT (niece) ADDRESS<br><b>Mrs. Elizabeth Lineberry Bel Air, Md.</b>             |   |   |

|   |   |  |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4100</b>   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerosis Cardiovascular Disease</b> |  |
|   | DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 27</b> , 19 <b>81</b> , to <b>March 27</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>March 27</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Susan Schwartz, M.D.</b>  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                   |  |  |  |

|   |                               |   |  |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>3/30/1981</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens Bel Air Harford</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>E. Barnes</b> ADDRESS<br><b>Fleming Funeral Home - Benson - Md. 21018</b> |                               | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>                                   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>         |

MEDICAL CERTIFICATION

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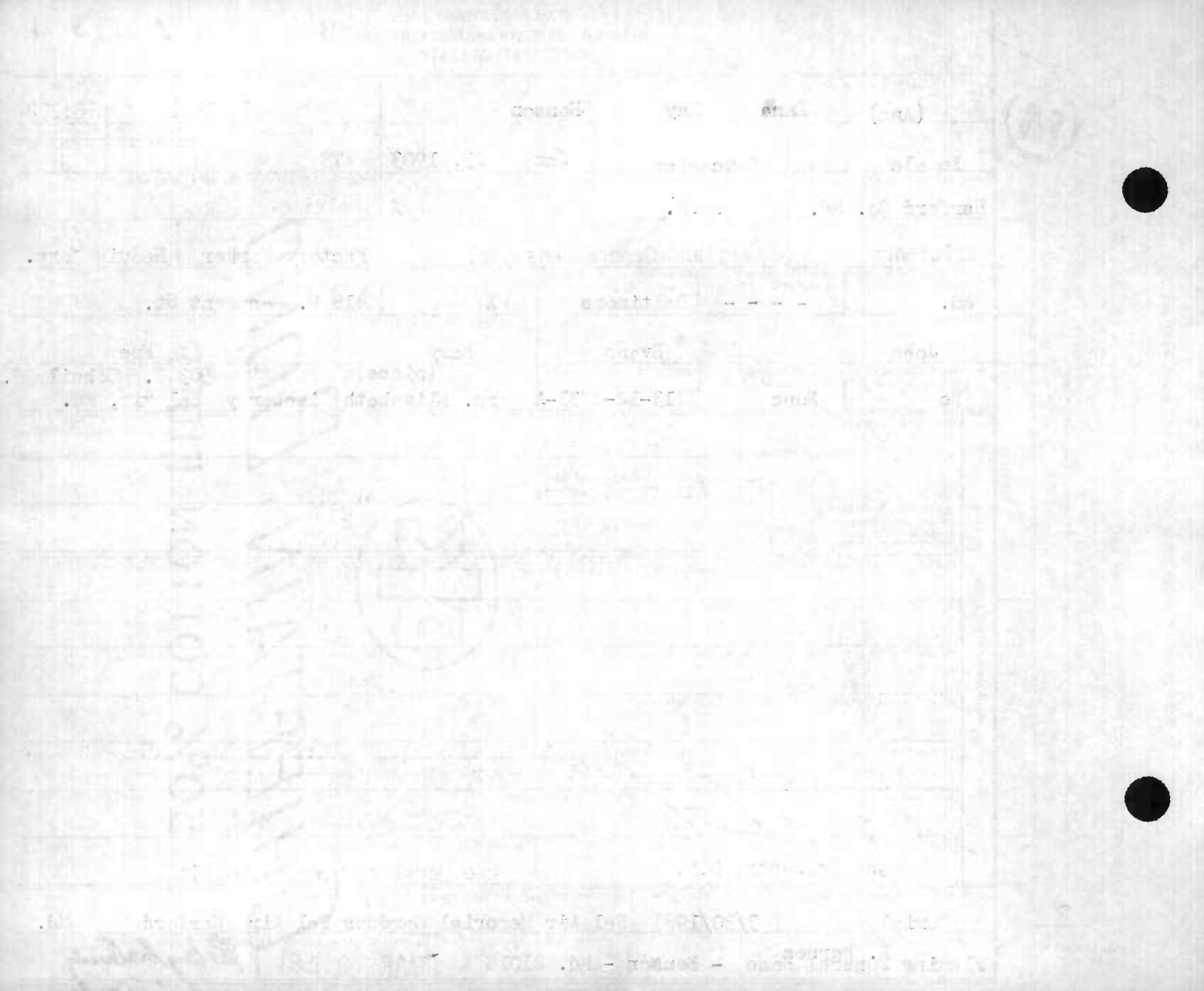
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8107039

|   |  |  |  |
|---|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>IRVIN NMI HARCUM   |  | MONTH DAY YEAR<br>3 18 81  |  |
| 2. SEX<br>MALE  |  | 3. RACE<br>Col.  |  |
| 4. DATE OF BIRTH  |  | 5. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MONTH DAY YEAR<br>12 14 25  |  | 55   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7. CITIZEN OF WHAT COUNTRY?  |  |
| BALTO MD.   |  | U.S.A  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
|   |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  |
| BALTIMORE   |  | Provident Hospital Balto MD  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Laborer   |  | Construction   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. INSIDE CITY LIMITS?   |  |
| 13a. STATE CITY OR TOWN   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| MD BALTO  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST<br>IRVIN NMI HARCUM   |  | FIRST MIDDLE LAST<br>Nannie NMI Bolden   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| NO  |  | 212-20-6501  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Mrs. Mary HARCUM  |  | -1650 N. Fulton Ave  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
|   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
|   |  |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/81</u> , 19 <u>81</u> , to <u>3/18/81</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>3/18/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |
| Nigel E.R. Jackman M.D.   |  |  |  |
| 22c. DATE SIGNED  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 3/18/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| NIGEL E.R. JACKMAN  |  | Provident Hosp. 2600, Liberty Light Ave<br>Baltimore MD  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  |
| Burial  |  | 3/21/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| MT. Auburn Cem.   |  | Westport MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Joseph R. Russ - 2222 W. North Ave  |  | MAR 20 1981  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |
|   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1893 U.S. 9444



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 7 0 4 0   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME  |  |  |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR   |  |  |  | MONTH DAY YEAR  |  |  |  |
| JAMES V HARNESS   |  |  |  | 03 08 81   |  |  |  | 2040 M  |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                                      |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>04 07 14   |  | 66 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |   |  |  |  |
| WEST VIRGINIA   |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| BALTIMORE   |  | UNIVERSITY OF MARYLAND   |  |  |  | RETIRED Inspector  |  | G.M. Corp   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| MARYLAND  |  |  |  | BALTIMORE  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14 FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  | 13e. STREET ADDRESS   |  |  |  |
| FIRST MIDDLE LAST<br>George HARNESS   |  |  |  | FIRST MIDDLE LAST<br>KATHARINE PLAUGHER  |  |  |  | 5407 CATALPA RD.  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |  | ADDRESS   |  |  |  |
| NO  |  |  |  | 233-34-748   |  | WIFE   |  | SAME.   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 HYPOTENSION<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>HEMORRAGE & ARRHYTHMIA<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>LONG TERM VENTILATORY INSUFFICIENCY AND STRESS-ULCER, 4mo.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>M.E. STRESS ULCER, Ca Lung, MALNUTRITION, SEPSIS |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |  |
| 10-16-80  |  | CARCINOMA OF LUNG  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-1, 1980, to 3-8, 1981, that (I) (we) last saw the deceased alive on 3-8, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| [Signature]   |  |  |  |  |  |  |  | 8 months  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| E O DOOLIN  |  |  |  | 22 SO GREEN ST. BALTO  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR                                       |  |  |  |
| Burial  |  | 3/11/81  |  | Dulaney Valley   |  | Baltimore, Maryland  |  | MAR 9 1981  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME   |  |  |  | 24b. ADDRESS   |  |  |  | 25. DATE SIGNED   |  |  |  |
| Leonard J Ruck Inc. Baltimore, Maryland   |  |  |  |  |  |  |  | [Signature]   |  |  |  |



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE

COL 114 FIVE

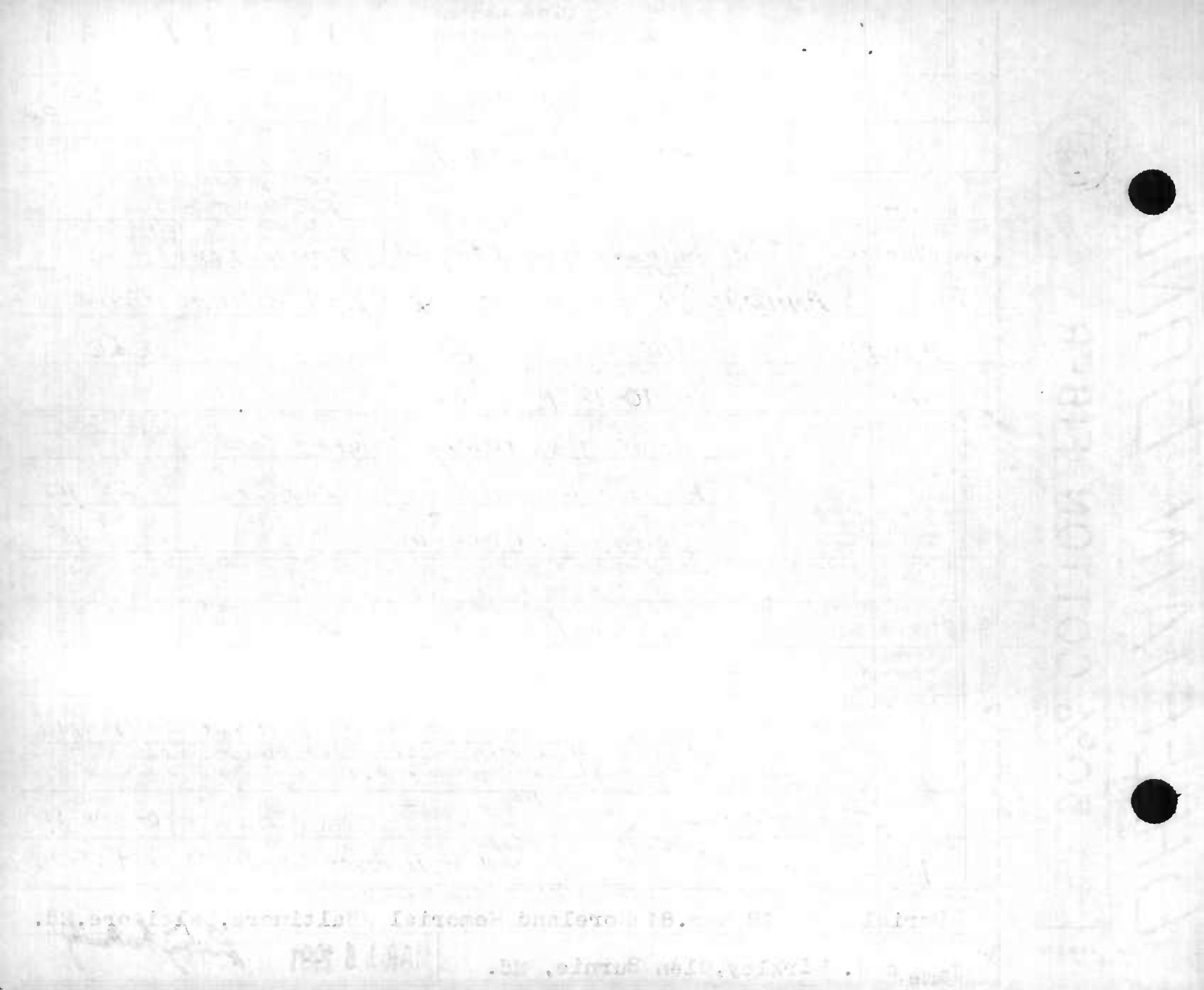
WHITE-131W-2



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 4 1

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH                                       |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST                                       |  | 03 14 81   |  | 645 P.M.  |  |
| CLARA OLIVE HARPER   |  | 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| F  |  | Cauc  |  | MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| PA   |  | USA   |  | Baltimore City   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | South Baltimore General Hospital                        |  | Homemaker  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Md   |  | ANNAPOLIS   |  | Glen Burnie  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST                                       |  | NO   |  | 209-10-7229   |  |
| RALPH CHESTER  |  | RHONDA BEAL   |  | 17. INFORMANT  |  | ADDRESS   |  |
|  |  |   |  | Chart  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4912 Acute respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Retained mucous bullous emphysema<br>DUE TO, OR AS A CONSEQUENCE OF (c) Chronic bronchitis<br>Approximate interval between onset and death: 25 yrs, 25 yrs. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| Flexible bronchoscopy  |  | Emphysema/Bronchitis                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION  |  |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | HOSPITAL  |  | 3001 So. Hanover, Baltimore, Balto Md  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 March, 19 81, to 14 March, 19 81, that (I) (we) lost saw the deceased alive on 14 March, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |   |  |
| Boulder  |  |   |  | 03-14-81   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |
| NABIL BADRO  |  | 3001 So. Hanover St, Balto., Md 21230                   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial   |  | 18 Mar. 81  |  | Moreland Memorial  |  | Baltimore, Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                           |  | 25b. SIGNATURE   |  |   |  |
| NAME ADDRESS   |  | MAR 16 1981   |  | F. Kirkley   |  |   |  |
| James S. Kirkley, Glen Burnie, Md.   |  |   |  |  |  |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

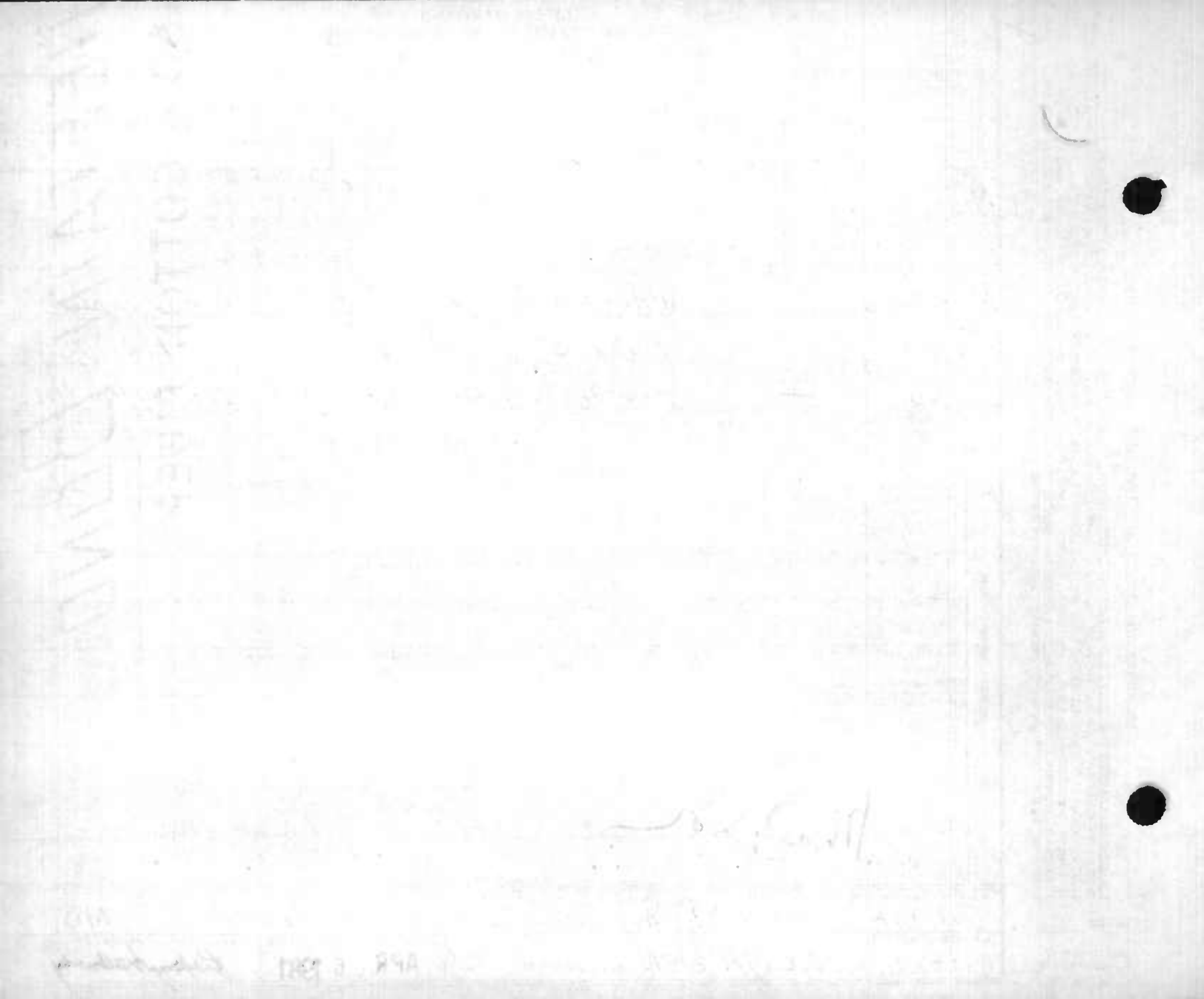
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
|--|--|---|--|---|--|---|--|---|--|--------------------------------|--|---|--|---|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>GRACE  |  | MIDDLE<br>L.  |  | LAST<br>HARRIS  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED                                       |  | MONTH<br>3                     |  | DAY<br>28   |  | YEAR<br>1981  |  | 2b. HOUR<br>10:15 |  |
| 3. SEX<br>female   |  | 4. RACE<br>negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 12 45   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>36 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                      |  | 2c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH<br>3  |  | DAY<br>28   |  | YEAR<br>1981      |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Mississippi  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |   |  |                                |  |   |  |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>914 Harlem Ave. |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>DOMESTIC  |  |                                |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                        |  |   |  |                   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>914 Harlem Avenue                                      |  |                                |  |   |  |   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Harris  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Harris  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| 16b. SOCIAL SECURITY NO.<br>426-72-7627  |  | 17. INFORMANT<br>Bennie Marshall  |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| 17. ADDRESS<br>914 Harlem Ave.   |  |   |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fatty metamorphosis of the liver<br>5718<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |                                |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                |  |   |  |   |  |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |                                |  |   |  |   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| ACTUAL SIGNATURE<br>Ann M. Dixon, M.D.   |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER  |  |                                |  | DATE SIGNED<br>3-29-81                                      |  |   |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |   |  | ADDRESS<br>111 Penn St.   |  |   |  |   |  |                                |  |   |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>4-7-81   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN CEM.                         |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. |  |   |  |                   |  |
| 24. FUNERAL DIRECTOR<br>CHAS. H. POWELL F/H  |  |   |  |   |  |   |  |   |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 6 1981                 |  | 25b. REGISTRAR'S SIGNATURE<br>Fitzgerald  |  |                   |  |

1601



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                         |  |   | 8 1 0 7 0 4 3   |  |
|--|-------------------------|--|---|---|--|
| 1. FOR STATE REGISTRAR   |                         |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen Harris</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 19, 1981</b>          |   | 2b. HOUR<br><b>10:50<sup>am</sup></b>                              |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 21 14</b>                   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                         |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                         |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>  |                         |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)      |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vansey Hayes</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Williams</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-7391</b>                        |   | 17. INFORMANT<br>ADDRESS<br><b>Bernard Harris 474 Cummings Ct.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>non-Histiocytic Lymphoma</b><br><b>2028</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)  |                         |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |  |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 3</b> , 19 <b>81</b> , to <b>March 19</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 19</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do) view the body after death. |                         |  |   |   |  |
| 22b. SIGNATURE<br><b>Eric Fisher</b>   |                         |  |   | 22c. DATE SIGNED<br><b>3/19/81</b>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>  |                         |  |   | 22c. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3-25-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>CHAS. A. RICE FSPA</b>  |                         | 24b. ADDRESS<br><b>1300 Eutaw Pl.</b>                                  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Robert A. ...</b>   |                         |  |   |   |  |

10:20

March 18, 1981

Harris

Kelton

Baltimore City

Maryland General Hospital

Baltimore

The Courtland House

Baltimore

St. James

10-20-70 - 10-20-70 - 10-20-70

non-Histocytic Lymphoma

Sepsis

x

x

March 19

51

March 2

March 19

xx

x

March 1

x

also Maryland General Hospital

Eric Fisher, M.D.

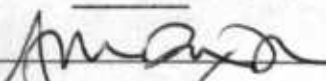

10-20-70 - 10-20-70 - 10-20-70

March 19, 1981

March 19, 1981



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |   |   |  |   |  | REG. NO. 07044  |  |
|--|------------------|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Samuel (SAM) HARRIS  |                  |   |  |   |   |   |  |   |  | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>3 27 19 81 |  |
| 3. SEX<br>male   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 6 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                  | IF UNDER 1 YR. MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.                                |   | 2c. DATE PRONOUNCED DEAD<br>3 27 19 81 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Greenville N.C.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>929 N. Madeira St. |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY      |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |   |  |   |   |   |  |   |  |   |  |
| 13a. STATE<br>Md   |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto                                  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>929 Madeira St.  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Buck Harris   |                  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lucy  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |                  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>237-14-4125                     |   | 17. INFORMANT ADDRESS<br>Anna Mae Cutlette 929 Madeira St.                                      |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |                  |   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |  |   |   |   |  |   |  |   |  |
| ACTUAL SIGNATURE    |                  |   |  | TITLE (SPECIFY)<br>M.D. Assistant                           |   |   |  | MEDICAL EXAMINER  |  | DATE SIGNED 3-28-81   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |                  |   |  | ADDRESS<br>111 Penn St.                                     |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>4/3/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Auburn Cemetery    |   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>William C. March F/H 1101 E. North Ave  |                  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1981  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |



UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WYOMING

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 4 5

REG. NO.

|   |  |   |   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN THOMAS HARRISON Sr.  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>3/16/81 |  |  | 2b HOUR<br>4:52pm  |  |  |  |  |  |  |  |  |
| 3 SEX<br>male   |  | 4 RACE<br>black   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7/31/27   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.                    |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8 IF UNDER 24 HRS<br>HOURS MIN   |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD    |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S. Public Health Service Hospital |   |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland  |  |   | 13b COUNTY<br>Baltimore                       |  |  | 13c CITY OR TOWN<br>Baltimore                                |  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e STREET ADDRESS<br>727 Bartlett Ave. Balto., Md #18 |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elijah Harrison  |  |   |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Wright |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  |   |   | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE YEAR OR DATES)<br>220 18 7304  |  |  |  | 16c RECORDS- 3100 Wyman Park Dr. Balto., Md 21211<br>U.S. Public Health Service Hospital   |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br>4255 Cardiac Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Alcohol, cardiomyopathy        |  |   |   |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 weeks   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 14a<br>Rt. lower lobe pneumonia, Acute myocardial infarct  |  |   |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 3/9/ 19 81 to 3/16 19 81, that (we) lost<br>saw the deceased alive on 3/16 19 81 and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br>L. L. Rivera, MD   |  |   |   |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>3/16/81   |  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. Rivera, M.D.   |  |   |   |  |  | 22e ADDRESS<br>3100 Wyman Park Drive Baltimore, Md. #11      |  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |   | 23b DATE<br>3/21/81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.         |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., MD.                             |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>WM.C.MARCH F/H INC.  |  |   |   |  |  | ADDRESS<br>1101 E. North Ave.                                |  |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 18 1981  |  |  |  |  |  |

BP



Washington, D.C.

1000 Pennsylvania Ave., N.W., Wash., D.C. 20004

Dear Mr. [Name]:

I am writing to you regarding the [Topic].

I have been thinking about the [Topic] and the [Topic].

I am sure that you will find this [Topic] of interest.

Sincerely,  
[Signature]

[Name]

1000 Pennsylvania Ave., N.W., Wash., D.C. 20004

Enclosure

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                             |  |   |   |  |  |   |  | REG. NO. 07046  |                                   |  |
|--|--|-----------------------------|--|---|---|--|--|---|--|---|-----------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                             |  |   |   |  |  |   |  |   |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert Paul Haughey</b>   |  |                             |  |   |   |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 11 19 81</b> |                                   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>        |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10-23-53</b>                         |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>27</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 2b. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>3 11 19 81</b> 2d HOUR <b>4:07A</b>  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  |  |                             | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                 |   |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Central District Police Station</b> |   |   |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gardner &amp; Housekeeper</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |   |   |  |  |   |  |   |                                   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Pr. Geo.</b> |  | 13c. CITY OR TOWN <b>Bowie</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2410 Keyberry La.</b>  |  |   |                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph W. Haughey</b>   |  |                             |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosemary Crooks</b> |  |  |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                             | (IF YES, GIVE WAR OR DATES) <b>-----</b>   |   |   | 16b. SOCIAL SECURITY NO. <b>216-46-6851</b>  |  | 17. INFORMANT ADDRESS <b>Rosemary Haughey Same as # 13</b>  |  |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia from hanging by neck</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                             |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                             |  |   |   |  |  |   |  |   |                                   |  |
| 19a. DATE OF OPERATION   |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                       |   |  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                             |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? 3/11 19 81</b>        |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>found hanging</b>  |  |   |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>cell</b> |   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Central Dist. Police Stat. Baltimore City, MD</b> |  |   |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                             |  |   |   |  |  |   |  |   |                                   |  |
| ACTUAL SIGNATURE <i>Hormez R. Guard</i>  |  |                             |  | TITLE (SPECIFY) <b>Assistant</b> M.D.                                   |   |  |  | MEDICAL EXAMINER DATE SIGNED <b>3/11/81</b>   |  |   |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                             |  | ADDRESS <b>111 Penn Street, Balto. MD 21201</b>                         |   |  |  |   |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |                             | 23b. DATE <b>3-13-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Lakemont Mem. Gard.</b>     |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davidsonville, Md.</b>                              |   |                                   |  |
| 24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b> ADDRESS <b>16,000 Annapolis Rd. Bowie, Md.</b>   |  |                             |  |   |   | 25a. DATE PREPARED <b>3-11-81</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. REGISTRAR'S SIGNATURE  |                                   |  |

16,000 Annapolis Rd. Bowie, Md.

8611 Funeral Home

Burial 3-13-81

Lakemont Mem. Care, Divisionville, Md.

James H. Smith, Jr.

211 South St., Baltimore, Md.

Residence

3714

Age

1900-1981, 81 years old, B. 12-22-1900

1st wife: Mary E. Smith, d. 1955

No

-----

216-66-6821 Rosemary Houghy 2 me as # 13

Joseph

W.

Houghy

Rosemary

Crooks

Mr.

Pat. Geo.

Bowie

x

2810 Kevberry Ln.

N.C.A.

New York

10-23-83 23

Page 1

XXXXXX

H. Houghy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |   |  |   |  |  |
|---|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA HAVENER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 16 1981                   |   |   | 2b. HOUR<br>11:54 AM  |  |   |  |  |
| 3 SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 18 1894   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |  |
| 13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James A. Mock   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rachel Wolford |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>179-22-4716   |  | 17. INFORMANT<br>208 South Woodwell Rd.<br>Balto., MD. 21222<br>Ruby L. Bender  |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE; HYPERTENSION<br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>DEHYDRATION; SENILE DEMENTIA   |  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that I (this hospital) attended the deceased from MARCH 9, 19 81, to MARCH 16, 19 81, that (I) (we) last saw the deceased alive on MARCH 16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |  |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br>A.F. NOUR, M.D.   |  |  |  |   |   | DEGREE MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>3-16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.F. NOUR, M.D.  |  |  |  |   |   | 22e. ADDRESS<br>100 N. BROADWAY BALTIMORE, MD. 21231<br>CHURCH HOSPITAL CORPORATION   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/19/1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Valley Forge Gdns.        |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>King Of Prussia Pa. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela...                          |  |  |

BP



APR 1981

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M/2/80

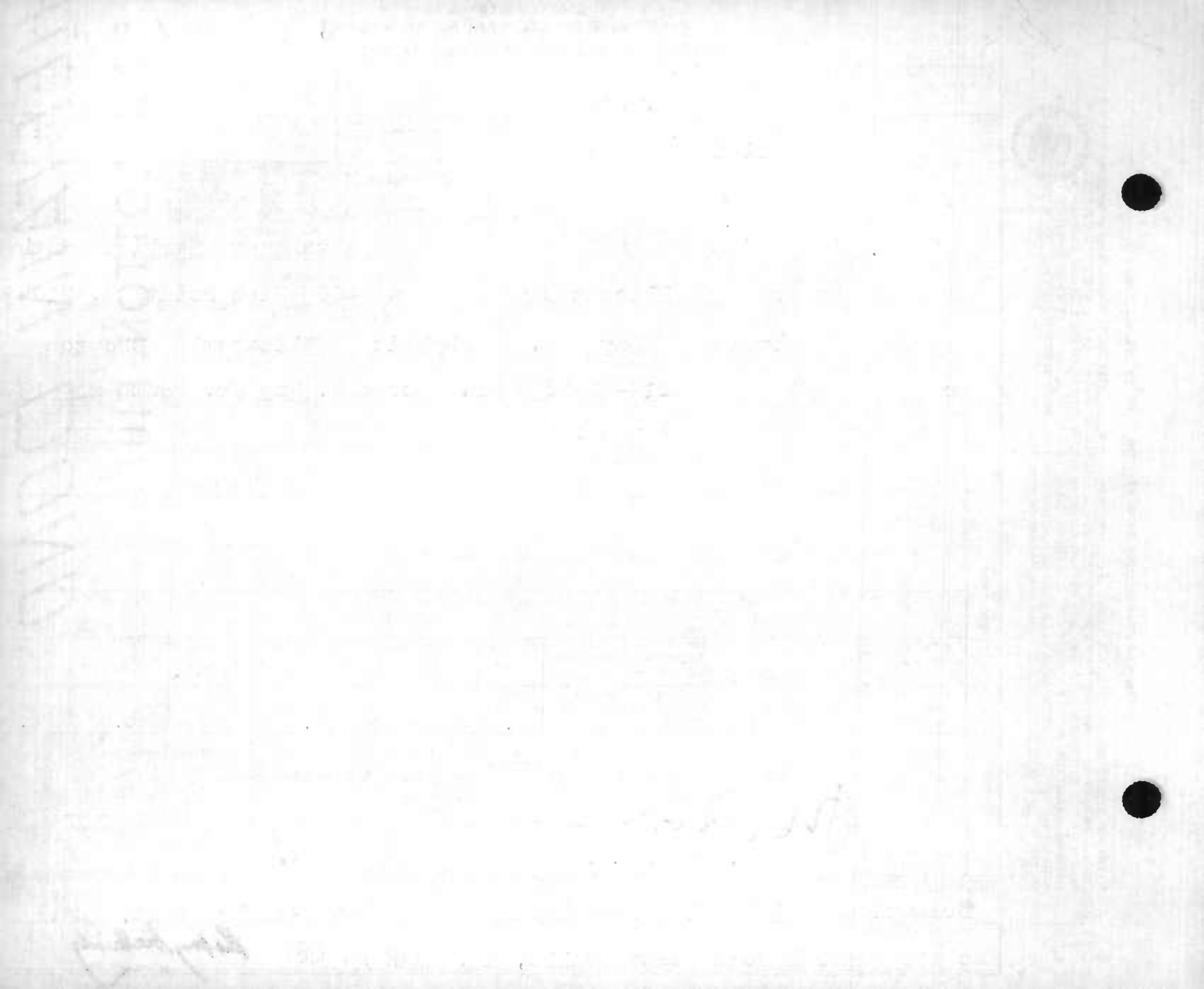
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07048

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. DATE OF DEATH   |  |  | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. DATE OF DEATH  |  |  | 2e. DATE OF DEATH  |  |  |
| ANN Frances HAY   |  |  | 3. SEX<br>female   |  |  | 4. RACE<br>white  |  |  | 5. DATE OF BIRTH<br>11/17/59  |  |  | 6. AGE (IN YEARS)<br>21 YRS.   |  |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 10. MARRIED<br>WIDOWED  |  |  | 11. NEVER MARRIED<br>DIVORCED   |  |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                              |  |  |
| 14. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital  |  |  | 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Attendant                                       |  |  | 17. KIND OF BUSINESS OR INDUSTRY<br>Service Station   |  |  | 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |  | 13b. CITY OR TOWN<br>Howard  |  |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13d. STREET ADDRESS<br>4005 High Point Rd. 21043   |  |  | 14. FATHER'S NAME<br>George Morris  |  |  | 15. MOTHER'S MAIDEN NAME<br>Phyllis Elizabeth   |  |  | 16. SOCIAL SECURITY NO.<br>214-82-8836   |  |  | 17. INFORMANT<br>Mr. George M. Hay Jr.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>8/120<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  | 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY<br>HOUR <del>XXX</del> MONTH DAY YEAR<br>1:42 P.M. 3-27-81   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver in auto/auto collision. |  |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt. 40 & Nowood Ave. Balto. Md. |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                     |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |  | 23b. DATE<br>3/29/81  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balt. Md.                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MacNabb Funeral Home Catonsville, Md.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 30 1981   |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  | 26. ACTUAL SIGNATURE<br>[Signature]   |  |  | 26. TITLE (SPECIFY)<br>Assistant   |  |  | 26. DATE SIGNED<br>3-28-81   |  |  |



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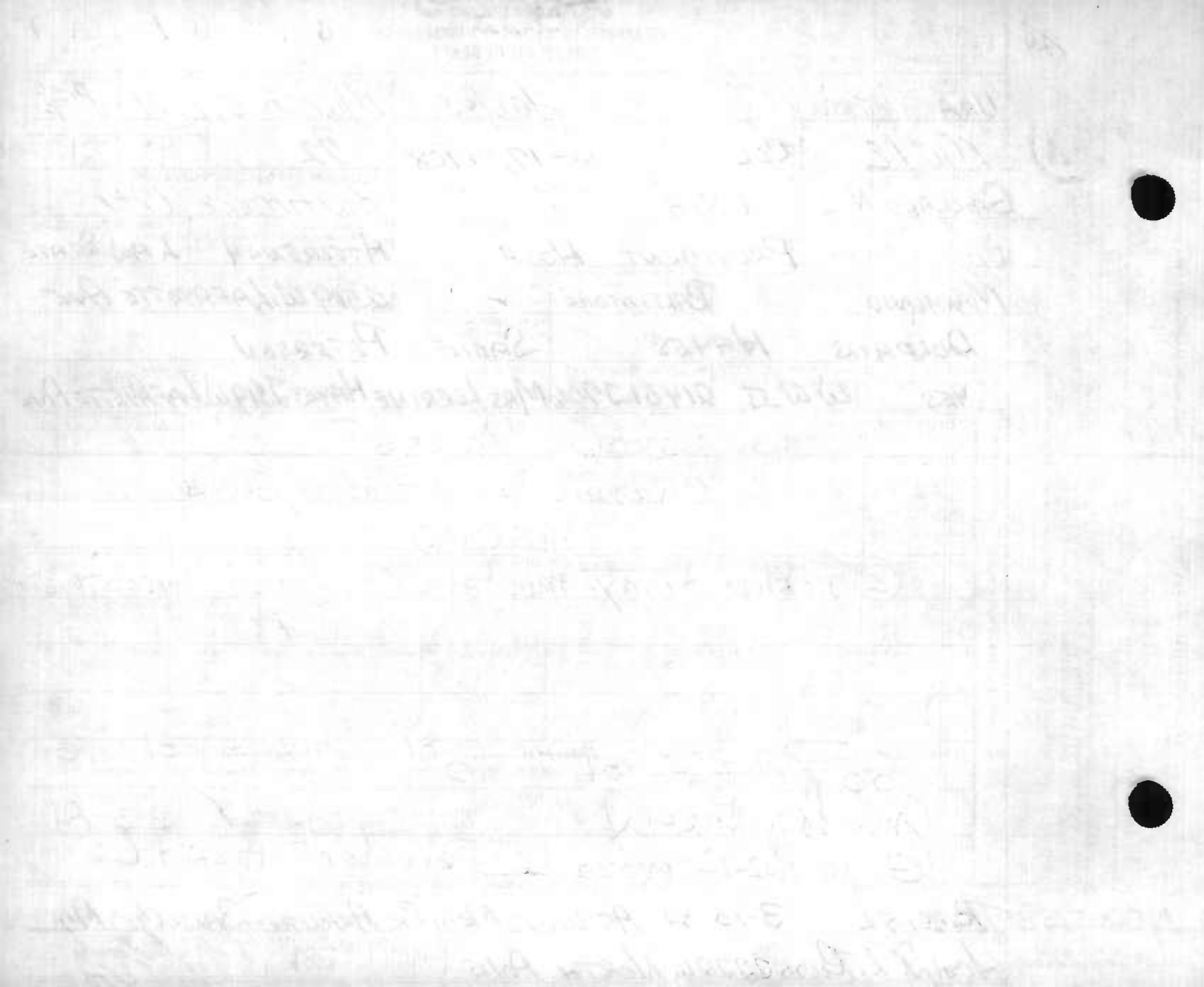
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 07049

20  
1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>URA Theodore  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 5, 1981   |  |  |  | 2b. HOUR<br>8:25 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Col   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>6-17-1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SARLAND N.C  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.                          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PROVIDENT HOSP |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ATTORNEY            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LAW STATE   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MARYLAND  |  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>DOLPHUS HAYES  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SADIE PETERSON  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES  |  |  |  | 16b. SOCIAL SECURITY NO<br>21401-2706   |  | 17. INFORMANT ADDRESS<br>MRS LOURINE HAYES 2519 W. LAFAYETTE AVE                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: }<br>(b) <u>Chronic Renal Failure, Severe</u><br>(c) <u>ASCVD</u>      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>(2) nephrectomy, Prostatic Co. Disease, Hypertension</u>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1981, to Mar. 5, 1981, that (I) (we) lost <u>see the deceased alive on Mar. 3, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death, ( ) ( ) |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Guido P. Guerezo  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>3-5-81   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Guido P. Guerezo   |  |  |  | 23b. ADDRESS<br>Provident Hospital  |  |  |  |  |  |
| 23c. BURIAL, CREMATION, REMOVAL (TYPE)  |  | 23d. DATE<br>3-10-81   |  | 23e. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM PK  |  | 23f. LOCATION CITY OR TOWN COUNTY STATE<br>ARBUTUS BALTIMORE MD                      |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Joseph L. Russo  |  |  |  | ADDRESS<br>2222 W. NORTH AVE  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 5 0

REG. NO.

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>INEZ M. HAYWORTH  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 1 81                          |   |   | 2b. HOUR<br>1230 PM  |   |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 08 26  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br>225 N. FULTON AVE   |  |  |  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HERMAN HAYWORTH  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA LEE              |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-80 3436 |   | 17. INFORMANT<br>ADDRESS<br>901 MAKEMARKET WOODLAND, Allendale St |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) cardiorespiratory failure<br>4310<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) left intracerebral hemorrhage<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 min.<br>2 days |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8/81, 19 81, to 3/1/81, 19 81, that (I) (we) last saw the deceased alive on 3/1/81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Charity C. Fox MD.<br>DEGREE   |  |  |  |   |   | 22c. DATE SIGNED<br>3/1/81   |   | 22e. ADDRESS<br>UNIVERSITY HOSPITAL  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARITY C. FOX MD.  |  |  |  |   |   | 22f. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3-5-81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MT Auburn Cem               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BROWN-THOMPSON F.H.  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1981  |   | 25b. REGISTRAR'S SIGNATURE<br>Ray M. Brady   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CARRIE O. HEADLONG  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 17 81   |  |   |  | 2b. HOUR<br>7:20 P.M.  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 8 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital                             |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>Balto., Md. 21216<br>3000 Chelsea Terrace.         |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Smith   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rhoda Bonner   |  |  |  | ADDRESS<br>Balto., Md. 21213  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>214-38-9434   |  | 17. INFORMANT<br>Mrs. Ethel A. Johnson 1811 N. Washington St.   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 Cancer of the Colon<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13/81, 1981, to 3/17/81, 1981, that (I) (we) last saw the deceased alive on 3/17/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Nigel E. R. Jackman M.D.  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/17/81   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NIGEL E. R. JACKMAN  |  |   |  |   |  | 22e. ADDRESS<br>Provident Hosp. 2600, Liberty High St. Ave.<br>Baltimore, Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3-22-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cemetery   |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter Funeral Home  |  |   |  | ADDRESS<br>Balto., Md. 21216<br>3035 W. North Ave.  |  | DATE REC'D. BY REGISTRAR<br>MAR 19 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                 |  |  |  |

MAR 19 1981

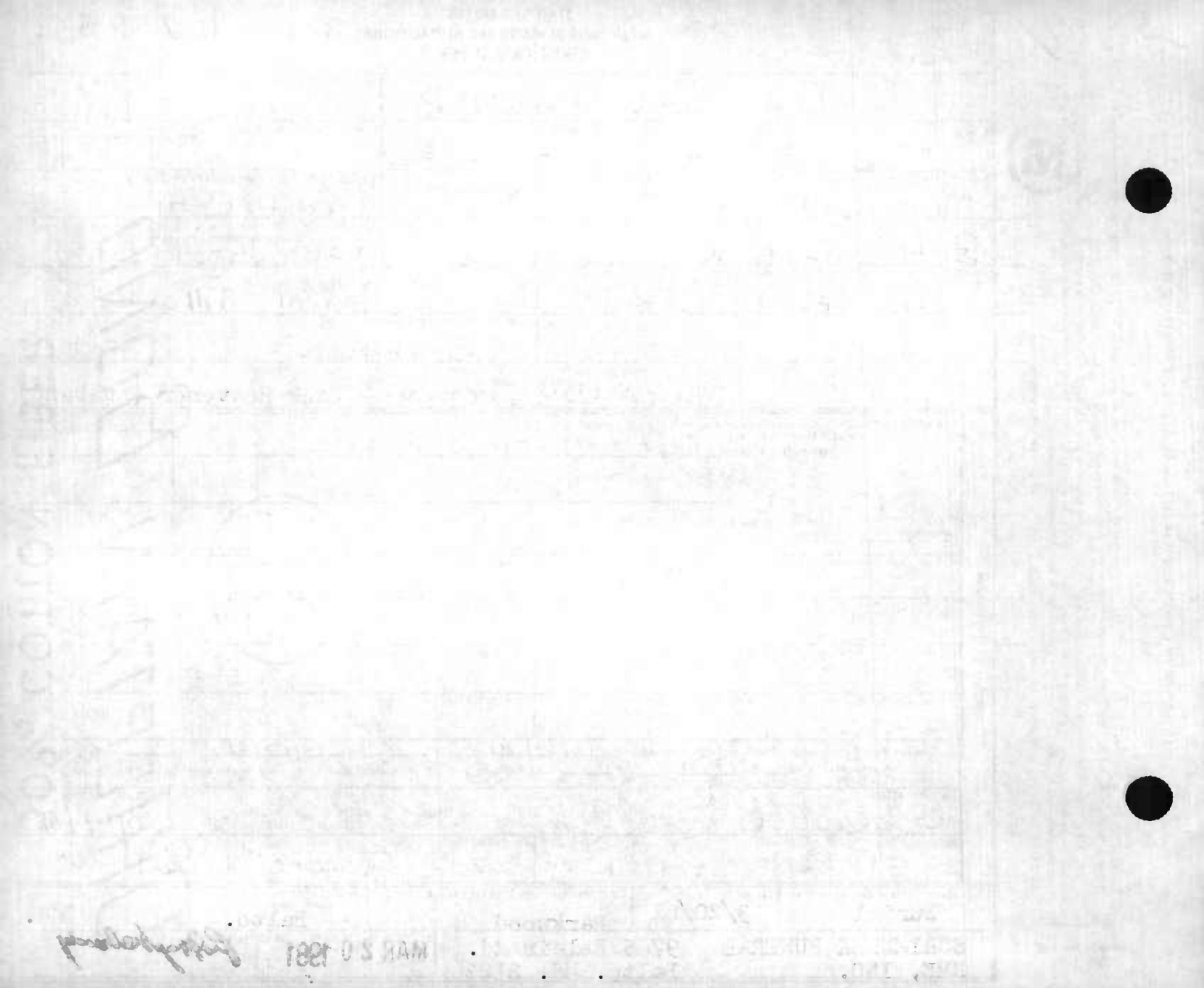
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 7 0 5 2   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOAN Carol HEAVENER   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>3 17 8 11 <sup>10</sup> AM   |  |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>Cauc   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 7 32   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                        |  |
| 7a. BIRTHPLACE (US OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BCRP University |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>radio dispatcher   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD. 13b. COUNTY<br>Balt. 13c. CITY OR TOWN<br>Balt.   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3904 Tilla Rd  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Weaver  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Beulah Fick   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-28-0150   |  | 17. INFORMANT ADDRESS<br>records & Jack Heavener (husband)  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 Oat cell carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/24/80, 19____, to 3/17/81, 19____, that (1) (we) lost saw the deceased alive on 3/17/81, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Elizabeth Poplin  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>3/17/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elizabeth Poplin   |  |   |  | 22e. ADDRESS<br>22 S. Greene St. Baltimore  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/20/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |
| 24. FUNERAL DIRECTOR<br>SCHIMUNEK FUNERAL HME, INC.   |  | 24b. ADDRESS<br>9705 Belair Rd. Balto. Md. 21236  |  | 25. DATE REC'D BY REGISTRAR<br>MAR 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>Elizabeth Poplin  |  |



2005 COTTON

*Handwritten signature*

1001 0 5 NAM

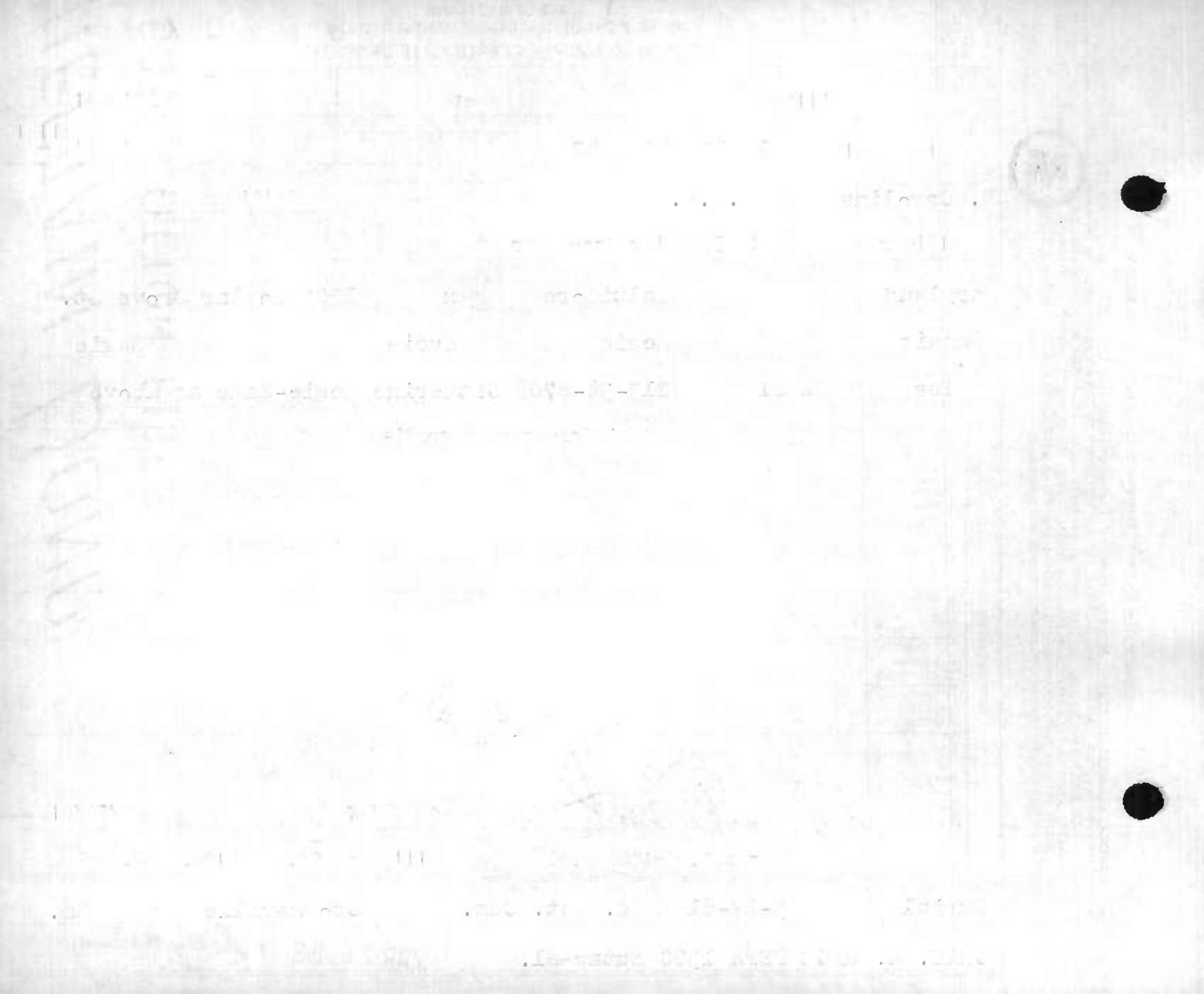
1001 0 5 NAM  
1001 0 5 NAM  
1001 0 5 NAM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |  | REG. NO. 07053  |  |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>William Heggie</b>   |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>3</b> DAY <b>21</b> YEAR <b>1981</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>13</b> YEAR <b>39</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>42</b> YRS  |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  | 2b. HOUR <b>11:10</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1203 Poplar Grove Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. CITY OR TOWN <b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1203 Poplar Grove St.</b>   |  |   |  |
| 14. FATHER'S NAME FIRST <b>Lennis</b> MIDDLE <b></b> LAST <b>Hegie</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Sudie</b> MIDDLE <b></b> LAST <b>Hegie</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>WW II</b>   |  | 17. INFORMANT ADDRESS <b>213-34-8708 Catherine Hegie-Same as Above</b>                       |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Acute intravenous narcotism</b><br><b>3049</b> IMMEDIATE CAUSE (a) <b>Acute intravenous narcotism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |                      |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural Causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>  |  |                      |  | TITLE (SPECIFY) <b>Deputy Chief</b> M.D. MEDICAL EXAMINER   |  |  |  | DATE SIGNED <b>3/22/81</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St. Balto., MD.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |                      |  | 23b. DATE <b>3-27-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vet. Cem.</b>                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>CHAS. A. RICE FSPA</b> ADDRESS <b>1300 Eutaw Pl.</b>  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 26 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>  |  |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

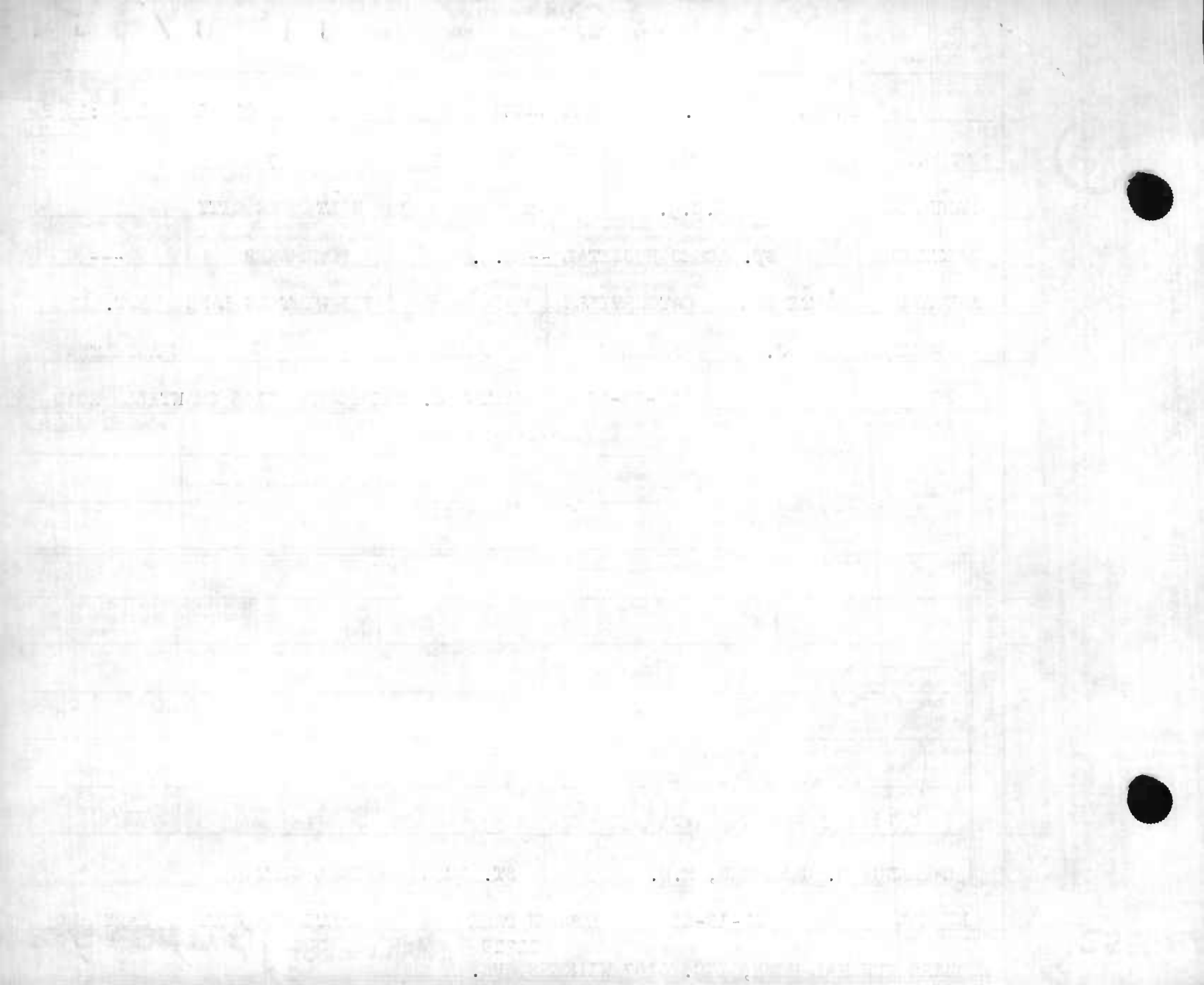
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 5 4

REG. NO.

|  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |   |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR                          |  |  | 2b. HOUR                                     |  |  |
| PEARL  |  |  | M.   |   |  | HEIDECKER   |  |  | 03 10 81                                |  |  | 4:19 PM                                      |  |  |
| 3 SEX  |  |  | 4 RACE   |   |  | 5 DATE OF BIRTH   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)          |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS              |  |  |
| FEMALE   |  |  | WHITE  |   |  | 07 28 10  |  |  | 70 YRS.                                 |  |  | MONTHS DAYS HOURS MIN.                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH     |  |  |  |  |  |
| MARYLAND   |  |  | U.S.A.   |   |  |   |  |  | BALTIMORE CITY MD.                      |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY       |  |  |  |  |  |
| BALTIMORE  |  |  | ST. AGNES HOSPITAL -- E.R.   |   |  | HOMEMAKER   |  |  | ---                                     |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13a. INSIDE CITY LIMITS?  |  |  | 13b. STREET ADDRESS                     |  |  |  |  |  |
| 13a. STATE   |  |  |  |   |  | 13c. CITY OR TOWN   |  |  | 715 WINTERS LANE APT. 124               |  |  |  |  |  |
| MARYLAND   |  |  |  |   |  | BALTIMORE   |  |  | CATONSVILLE                             |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  |   |  | FIRST MIDDLE LAST   |  |  |   |  |  |  |  |  |
| WALTER J. MELZER   |  |  |  |   |  | PEARL SCHANFELTER   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |   |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS                   |  |  |  |  |  |
| NO   |  |  |  |   |  | 217-52-2508   |  |  | WALTER J. HEIDECKER 2146 CHANTILIA ROAD |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 1 DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Acute myocardial infarction  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| (b) Hypertensive arteriosclerotic coronary artery disease  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| (c)  |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
|  |  |  |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |  |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR<br>XXXX P.M. XXXXXX 19                     |  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  |   |  |   |  | STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/28/79, 19, to 3/10/81, 19, that (I) (we) last saw the deceased alive on 2/17/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |   |  |  |  |  |  |
| Laurence R. Gallagher, M.D.  |  |  |  | MD  |  |   |  | 3/11/81  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |   |  |  |   |  |  |  |  |  |
| LAURENCE R. GALLAGHER, M.D.  |  |  |  | ST. AGNES MEDICAL CENTER  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |   | 23d. LOCATION  |  |  |  |  |
| BURIAL   |  |  |  | 03-13-81  |  | LOUDON PARK   |  |  |   | BALTIMORE CITY MARYLAND  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |  |  |  |
| NAME   |  |  |  | ADDRESS   |  |   |  | MAR 13 1981  |   |  |  |  |  |  |
| HUBBARD FUNERAL HOME, INC.   |  |  |  | 4107 WILKENS AVE.   |  |   |  |  |   |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for the funeral home to use in obtaining a permit for removal of the body. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION: 10/23/81

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  | 8 1 0 7 0 5 5  |  |
|---|--|--|--|--|--|--|--|
| FOR<br>1 - STATE REGISTRAR  |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank EDWARD Heilman</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 23, 1981</b>  |  | 2b. HOUR<br><b>6:40pm</b>  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br><b>10-31-02</b> YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Industrial</b>                                       |  |
| 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>  |  |  |  | 13b COUNTY<br><b>---</b>   |  | 13c CITY<br><b>BALTIMORE</b>   |  |
| 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e STREET ADDRESS<br><b>711 N. Curley Street</b>  |  |  |  |
| 14 FATHER'S NAME<br><b>HENRY C. HEILMAN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>ANNA E.</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b SOCIAL SECURITY NO<br><b>218098613</b>   |  | 17. INFORMANT ADDRESS<br><b>ANGELA HAUF 711 N. CURLEY STREET</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>4442</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Probable Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Illness (Altered Mental Status)</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Schizophrenia / Part Myocardial Infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>3/16/81</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Arterial Emboli @ leg</b>  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>81</b> , to <b>3/23</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/23</b> , 19 <b>81</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Arthur Klein</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>3/23/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur Klein</b>  |  |  |  | 22e. ADDRESS<br><b>600 N. Wolfe St.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-26-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>John G. Gaud</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>2716 E. Monument St.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>MAR 26 1981</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8 1 0 7 0 5 6  |   |
|---|---|---|---|--|---|
| 1. FOR STATE REGISTRAR  |   |   |   | REG. NO.   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marie Anna Hemmeter  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 4, 1981                             |  | 2b. HOUR<br>11:00A <sub>M</sub>   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 2 06   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.   |   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Samuel Loehr   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth Albert                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>216-52-0393   |   | 17. INFORMANT ADDRESS<br>Mildred Hemmeter, 338 S. East Avenue<br>Baltimore, Md.      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> , 19 <u>79</u> , to <u>MARCH 4</u> , 19 <u>81</u> , that (I) (we) lost<br>saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.          |   |   |   |  |   |
| 22b. SIGNATURE<br><u>Melito M. Torres</u> DEGREE  |   |   |   | 22c. DATE SIGNED<br>3-6-81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Melito M. Torres   |   |   |   | 22e. ADDRESS<br>441 S. Ellwood Ave 21224   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>3-7-81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery Baltimore Md.           |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 6 1981   |   |  |   |
| 24. FUNERAL DIRECTOR<br>Nicholas T. Matthews, 3021 Eastern Avenue<br>Baltimore, Md.   |   |   |   |  |   |

1992

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 5 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN J. HENDERSON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 7, 1981</b>            |   |  | 2b. HOUR<br>MIN.<br><b>11:55PM</b>   |   |  |  |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/16/13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>11:55PM</b>  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>ESSEX</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1715 HILLTOP AVE</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MONROE J. HENDERSON</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY NEARY</b>  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>21207-1224</b>                          |   | 17. INFORMANT<br><b>JOHN P. HENDERSON</b>                                      |  |   |  | ADDRESS<br><b>641 DUNWICH WAY</b>              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST - NO VENTILATORY DRINE</b><br>4310<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>INTRACEREBRAL HEMORRHAGE</b><br>24 HOURS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSIVE CRISIS</b><br>28 HOURS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MINUTES</b> |  |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>81</b> , to <b>3/7</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Eric J. Seifter</b>  |  |  |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3/8/81</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERIC J. SEIFTER</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>3/11/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b>                      |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Connelly Funeral</b>   |  |  |  |   |  | ADDRESS<br><b>Home 300 Mace Ave</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4d Pd 2Pl 2

1850



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                  |   |  | 8 1 0 7 0 5 8   |                        |
|---|------------------|---|--|---|------------------------|
| 1. FOR STATE REGISTRAR  |                  |   |  | REG. NO.  |                        |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALICE HENRY   |                  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 18 81 |   | 2b. HOUR<br>10:40 P.M. |
| 3. SEX<br>FEMALE  | 4. RACE<br>BLACK | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 18 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.  |                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |                        |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |                  | 13b. COUNTY<br>BALTO. CITY  | 13c. CITY OR TOWN<br>BALTIMORE                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISRAEL  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENCE WHITE   |  | 13e. STREET ADDRESS<br>2210 WHITTIER AVE.   |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>219-26-1327   |  | 17. INFORMANT<br>MILLARD HENRY  |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 0389 CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) LOW GRADE SEPTIS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                     |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                  |   |  |   |                        |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/18/81, to 3/18/81, that (1) (we) lost saw the deceased alive on 3/18/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |                  |   |  |   |                        |
| 22b. SIGNATURE<br>Leonard Bielory, M.D.   |                  | DEGREE  |  | 22c. DATE SIGNED<br>3/18/81   |                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEONARD BIELORY, M.D.  |                  | 22e. ADDRESS<br>8 Charles Plaza 1606 NT Baltimore, Md.  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |                  | 23b. DATE<br>3/21/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CARROLL WESTERN Cem. CALVERT Co. Md.  |                        |
| 24. FUNERAL DIRECTOR<br>NAME<br>VERNON BIELORY  |                  | ADDRESS<br>1348 CALHOUN ST  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981  |                        |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |                  |   |  |   |                        |

INVESTIGATION NO. 254  
DATE OF INVESTIGATION: 12/10/75  
BY: J. H. [illegible]

11/16

9

11/16/75

11/16/75



*[Handwritten signature]*

1001 U.S. MAIL

3  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07059

|  |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
|--|--|---|--|--|--|--|--|--|--|--|--|---|--|---|--|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Melvin   |  | MIDDLE<br>Herman   |  | LAST<br>Herman   |  | 2a. DATE KNOWN OF DEATH  |  | MONTH<br>3                                 |  | DAY<br>14   |  | YEAR<br>81                                |  | 2b. HOUR<br>12:52 |  |
| 3. SEX<br>male   |  | 4. RACE<br>black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 27 1949  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>31 YRS.             |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 14 81                               |  | 2d. HOUR<br>12:52                         |  | 2e. AM<br>AM      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TEXAS   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City |  |  |  |  |  |   |  |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FISHERS |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FISHING  |  |   |  |                   |  |
| 13a. STATE<br>CALIF  |  | 13b. CITY OR TOWN<br>Los Angeles  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>226 E. 145th ST.                |  |  |  |  |  |   |  |   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CALVIN HERMAN  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>THEALA DAVIS   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO NONE  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT (sister) ADDRESS<br>DELORES DUMAS SAME AS #13   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple stab wounds of chest<br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>10:00PM 3/13 81  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject stabbed   |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>sidewalk   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>225 W. Fayette St, Baltimore City MD  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| ACTUAL SIGNATURE<br>H. R. Guard  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED<br>3/14/81  |  |   |  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, MD.   |  | ADDRESS<br>111 Penn Street, Baltimore, MD 21201   |  |  |  |  |  |  |  |  |  |   |  |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>4-10-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD               |  |  |  |   |  |   |  |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E. BARNES  |  | ADDRESS<br>FLEMING Funeral Service - Benson Rd  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 10 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>R. H. H. H. |  |                   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

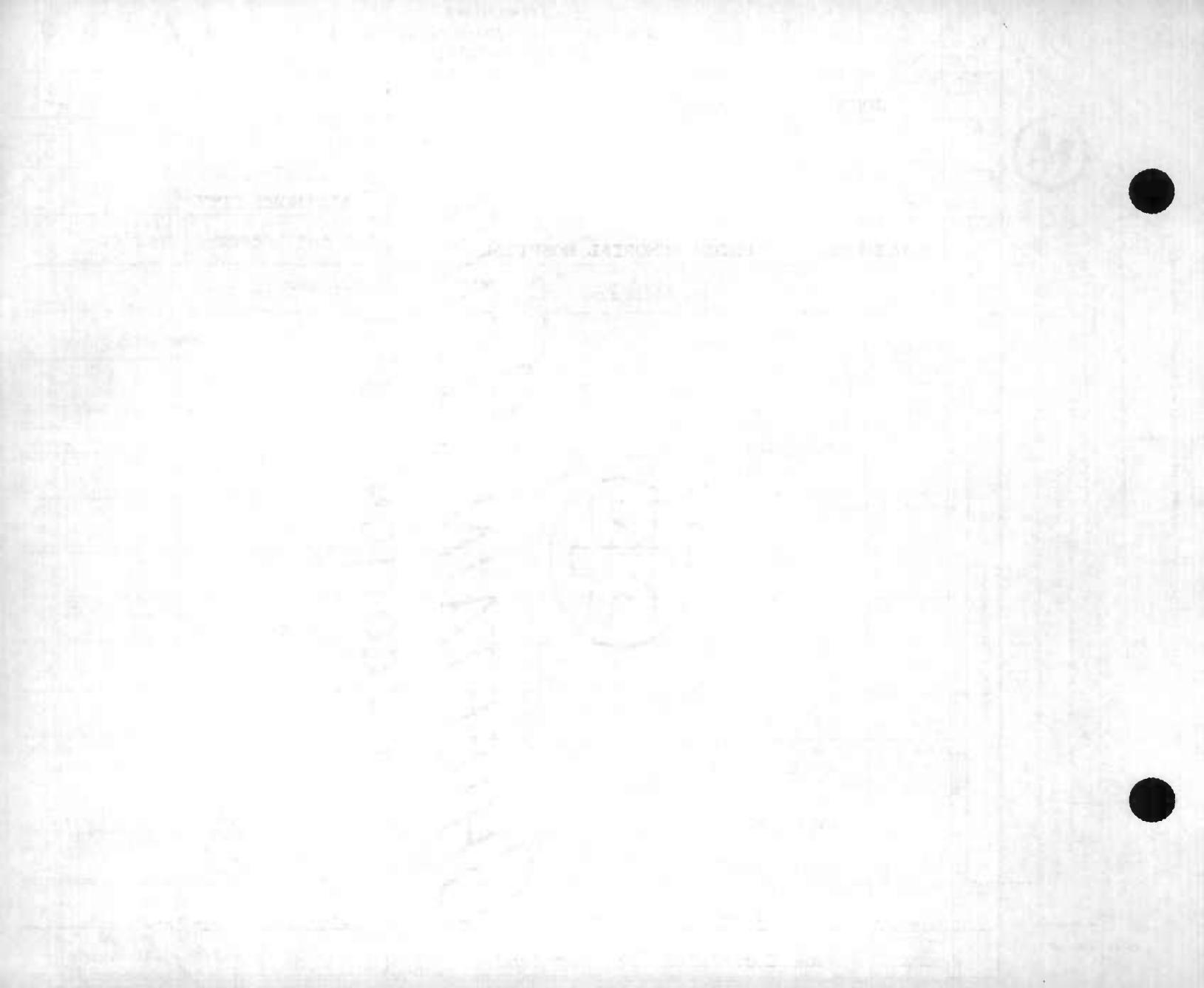
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 6 0

|  |  |  |   |
|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOHN Francis HERR Sr   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 27 81  |   |
| 3. SEX<br>Male   | 4. RACE<br>White                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>January 15, 1916  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>65  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland |  | 8. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL  |  | 12a. USUAL OCCUPATION (TYPE OF PEOPLE FOR MOST OF WORKING LIFE)<br>Retired Letter  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Carrier   |  | 13a. STATE<br>Maryland   |   |
| 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3122 Mary Ave   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Herr  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Warmuth   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-10-0228  |   |
| 17. INFORMANT<br>Mrs Mary R Herr   |  | ADDRESS<br>Same  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Staph Sepsis, Abscess in lung<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF,<br>(b) Renal failure<br>DUE TO, OR AS A CONSEQUENCE OF,<br>(c) Cerebrovascular Accident                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2/27/81 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |   |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27, 19 81, to 3/27, 19 81, that (I) (we) lost saw the deceased alive on 2/26, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Mama Stark   |  | 22c. DATE SIGNED<br>3/27/81  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mama Stark  |  | 22e. ADDRESS<br>Union Memorial Hospital  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/31/81   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |   |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981   |   |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

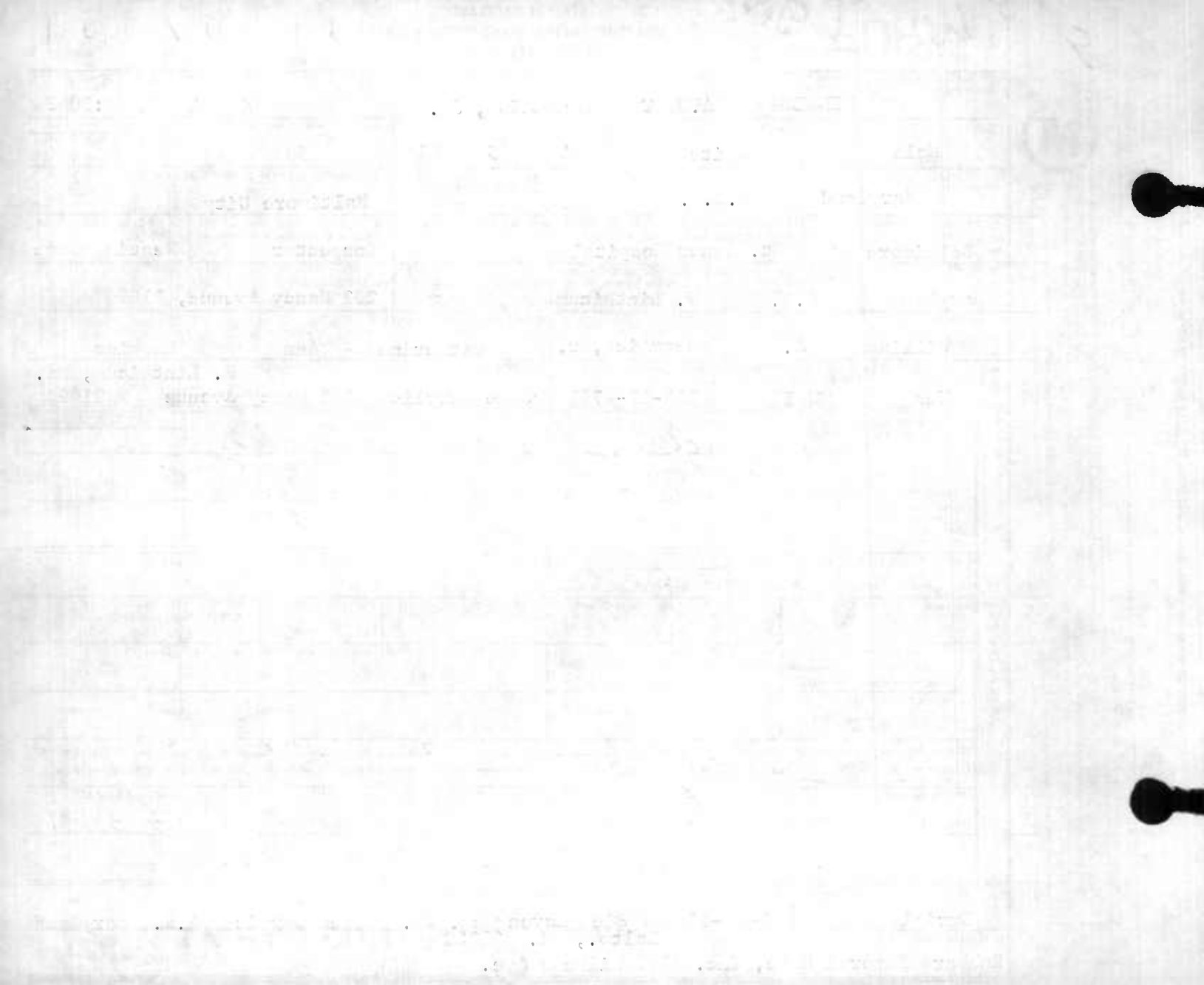
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |   |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>WILLIAM AUGUST HERRLICH JR.  |  |  |  |  | 2r. DATE OF DEATH MONTH DAY YEAR<br>03 02 81   |  | 2b. HOUR<br>5:30 P.M.                          |  |   |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>12 5 21  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                                  |  | 7a. IF UNDER 1 YEAR MONTHS DAYS<br>7b. IF UNDER 24 HRS. HOURS MIN.   |   |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7d. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |  |  |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN N. Linthicum  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>202 Nancy Avenue, 21090 |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William A. Herrlich   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Ann Hopkins                          |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO<br>WW II 212-12-4791   |  | 17. INFORMANT ADDRESS<br>June Herrlich 202 Nancy Avenue N. Linthicum, Md. 21090  |  |  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>hyperkusic arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>coronary artery disease</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>h</u><br><u>yr</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes mellitus</u>  |  |  |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 19 81, that (I) (we) lost the deceased alive on 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br>Laurence R. Gallagher, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br>3-3-81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurence R. Gallagher, M.D.   |  |  |  | 22e. ADDRESS<br>3455 Wilkens Avenue Balto. Md. 21229   |  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>03-06-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Maryland       |  |  |   |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |  | 24b. ADDRESS<br>Balto., Md. 21229  |  | 25. DATE REC'D. BY REGISTRAR<br>MAR 6 1981                                 |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 0 6 2  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |   |  |  |   |                             |  |
|--|--|--|--|--|---|--|--|---|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>August C. Hess  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 21 81                         |  |   | 2b. HOUR<br>12:50 PM   |  |   |                             |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 99  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.  |                             |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.  |  |   |                             |  |
| 12. CITY OR TOWN OF DEATH<br>Baltimore   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |  |   | 14a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |  | 14b. KIND OF BUSINESS OR INDUSTRY<br>Penn. R.R.   |                             |  |
| 15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br>Maryland   |  | 15b. COUNTY<br>Baltimore   |  | 15c. CITY OR TOWN<br>Fullerton   |   | 15d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 15e. STREET ADDRESS<br>4924 Ridge Road 21236  |                             |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Hess   |  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna                  |  |   |  |  |   |                             |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 18b. SOCIAL SECURITY NO.<br>None                                       |  |   | 19. INFORMANT<br>Roland Hess 4924 Ridge Road   |  |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diffuse severe anoxic brain damage</u><br>3481<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metabolic / hepatic encephalopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>coronary of liver, CHF.</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>CHF. probable A-T. bleeding.</u> |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                             |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>81</u> , to <u>3/21</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |   |                             |  |
| 22b. SIGNATURE<br><u>Bluel Ray</u>   |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>3/21/81 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAJARAM, ANDAL  |  |  | 22e. ADDRESS<br>Good Samaritan Hospite                                 |  |   |  |  |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>3/24/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville Baltimore, Md.  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  |  | ADDRESS<br>7401 Belair Road  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                             |  |

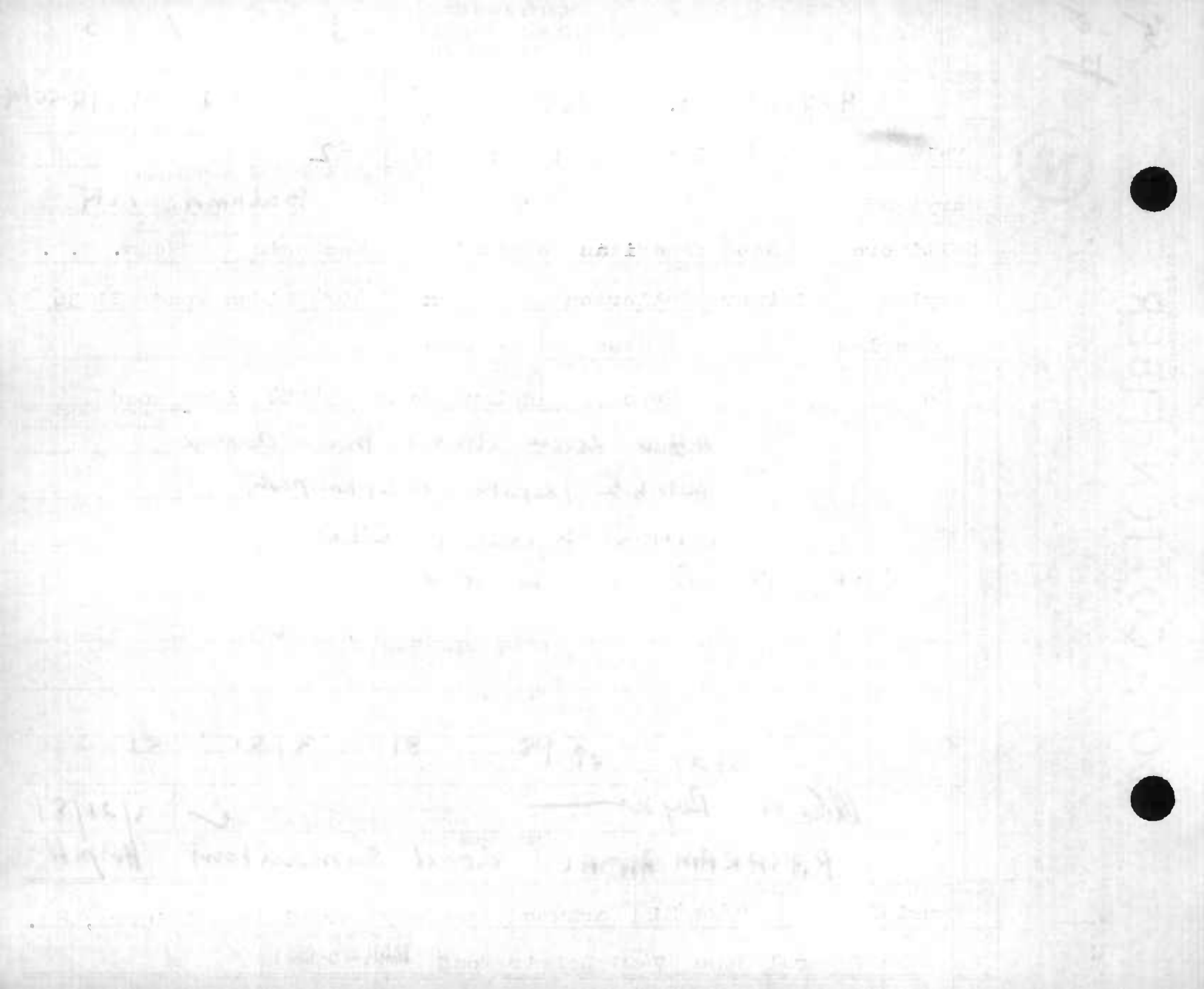
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.



Item 6 8554 4/7/81 gj

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 0 6 3  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN W. HIEBLER</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03-18-81</b>  |   | 2b. HOUR<br><b>7:40pm</b>   |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 04 11</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70-69</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BUILDING</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN HIEBLER</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLEN MEYERS</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212091484</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MARGARET HIEBLER 23 N. CLINTON ST.</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 LUNG CANCER WITH METASTASIS</b><br>IMMEDIATE CAUSE (a) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02-21-</b> <b>81</b> to <b>03-18-</b> <b>81</b> that (I) (we) last saw the deceased alive on <b>03-18-</b> <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                 |  |   |   |   |  |
| 22b. SIGNATURE<br><b>DR. A. F. NOUR</b>   |  | DEGREE <b>MD</b><br>22c. DATE SIGNED<br><b>3-18-81</b>  |   | 22d. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b><br><b>100 N. BROADWAY BALTIMORE, MARYLAND 31</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/21/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILLS</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO BALTO. MD.</b>   |  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Johy Carl</b> ADDRESS <b>1211 Chesaw Ave.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1981</b>  |   | 26. REGISTRAR'S SIGNATURE   |  |

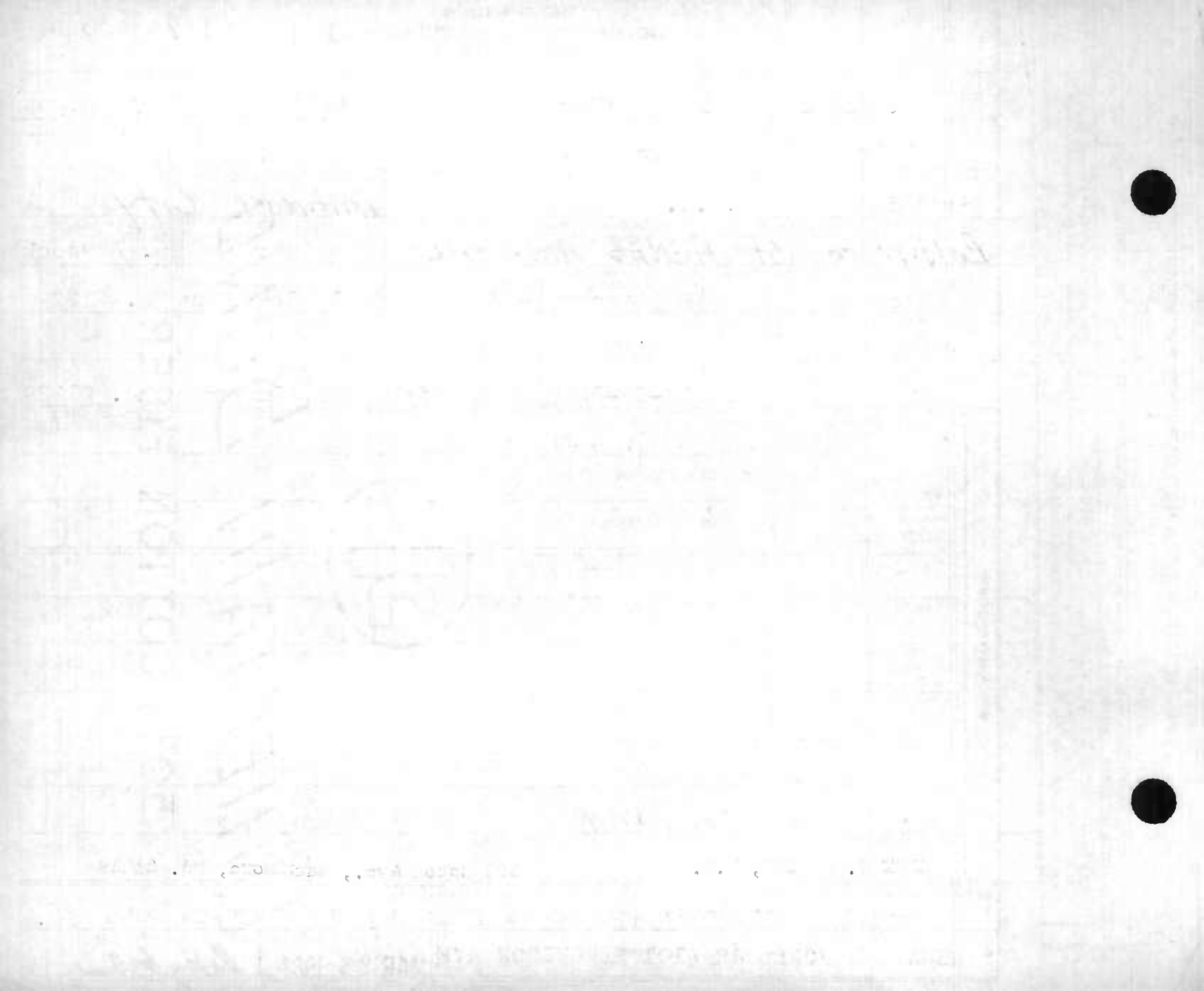


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |   | 8 1 0 7 0 6 4  |  |
|--|--|--|--|---|--|---|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   |  |   |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clinton C High</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 3 21 81</b>                                     |  |   | 2b. HOUR<br><b>10:55<sup>AM</sup></b>                           |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 3 17 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder</b>               |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>d. Drydock</b>          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4401 Flowerton Rd. 21229</b>  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John High</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose ?</b>  |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-3465</b>   |  | 17. INFORMANT<br><b>Zelma High/4401 Flowerton Rd. 21229</b>   |  |   |  | ADDRESS   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4151 IMMEDIATE CAUSE (a) Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Bert F. Morton, M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERT F. MORTON, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>900 Caton Ave., Baltimore, Md. 21229</b>   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>03/25/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDEN OF ETERNAL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FINKSBURG CARROLL MD.</b>                      |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL W JONES JR/4101</b>  |  |  |  | ADDRESS<br><b>EDMONDSON AVE</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Robert A. Bandy</i> |  |





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 7 0 6 5   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SAMUEL ALEXANDER HIGH, SR.  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 5, 1981  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 15, 1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6229 Northwood Drive |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clergyman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Religious   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland   |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hubert High  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Pearl Payseur   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>243-24-8311  |  | 17. INFORMANT<br>RACHEL A. HIGH   |  | 17. ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>3220</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>cardiac arrhythmia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF <u>Parkinson's Disease</u><br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Thomas Preziosi</u> MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THOMAS PREZIOSI, M.D.   |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL, BALTO., MD.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 9, 1981   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Saters Baptist Church   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 9 1981   |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. L. L.</u>  |  |

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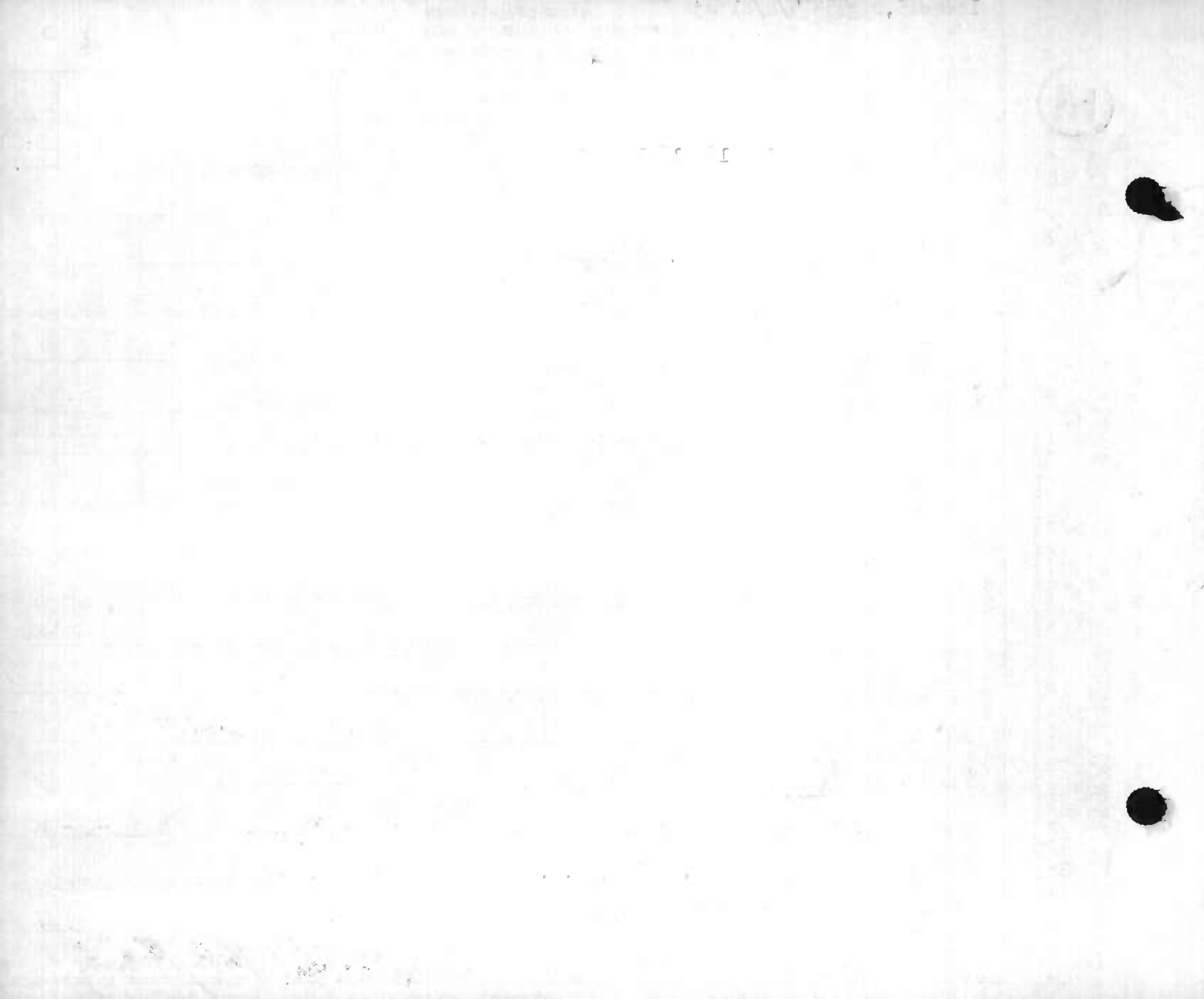
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |   |  |   |  |   |  | REG. NO. 07066   |  |                                   |  |
|--|--|------------------|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Core (Cora) J. Hill   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3 24 1981 |  | 2b. HOUR<br>M                     |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 16 1891   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>89                                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 24 1981                            |  | 2d. HOUR<br>3:40<br>P.M.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2502 N. Ellamont Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE<br>Md.  |  |                  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2502 N. Ellamont St.  |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unkn   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unkn                         |  |   |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-07-4618  |  | 17. INFORMANT<br>ADDRESS<br>Ellwood Beale 2200 Tucker La.                     |  |   |  |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |  |   |  |   |  |   |  |  |  |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |  |   |  |   |  |   |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |                                   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | DATE SIGNED<br>3-25-81  |  |  |  |                                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street  |  |   |  |   |  |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>3/30/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Md.                     |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |                  |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela Brady  |  |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 6 7

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET ELLEN HILL</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 - 1-81</b> |  |  | 2b. HOUR<br><b>8:04 A</b>   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 - 7 - 1896</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1410 MC CULLOH STREET</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC PVT</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FAMILIES</b>                                  |  |   |  |  |  |   |  |

|  |  |             |  |  |  |   |  |   |  |
|--|--|-------------|--|--|--|---|--|---|--|
| 13a. STATE<br><b>MARYLAND</b>                                |  | 13b. COUNTY |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1410 MC CULLOH STREET</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JACKSON WARD</b> |  |             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KITTIE SMITH</b> |  |   |  |   |  |

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>215-22-1720</b> |  | 17 INFORMANT<br>ADDRESS<br><b>MATTIE K. BLACKWELL 1613 MORELAND AVE</b> |  |  |  |
|---|--|--|--|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Arrest</b><br><b>4291</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min</b><br><b>3 min</b> |  |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-4-1980</b> to <b>3-1-1981</b> , that (I) (we) lost saw the deceased alive on <b>3-1-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>G. Franklin Phillips M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>3-3-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G, FRANKLIN PHILLIPS M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>558 MTMECHEN STREET</b>                                     |  |  |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                           |  | 23b. DATE<br><b>3-4-81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN CEMETERY</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HERBERT E. NUTTER 3035-37 W. NORTH AVE</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1981</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                      |  |



UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

OFFICE OF THE ATTORNEY GENERAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

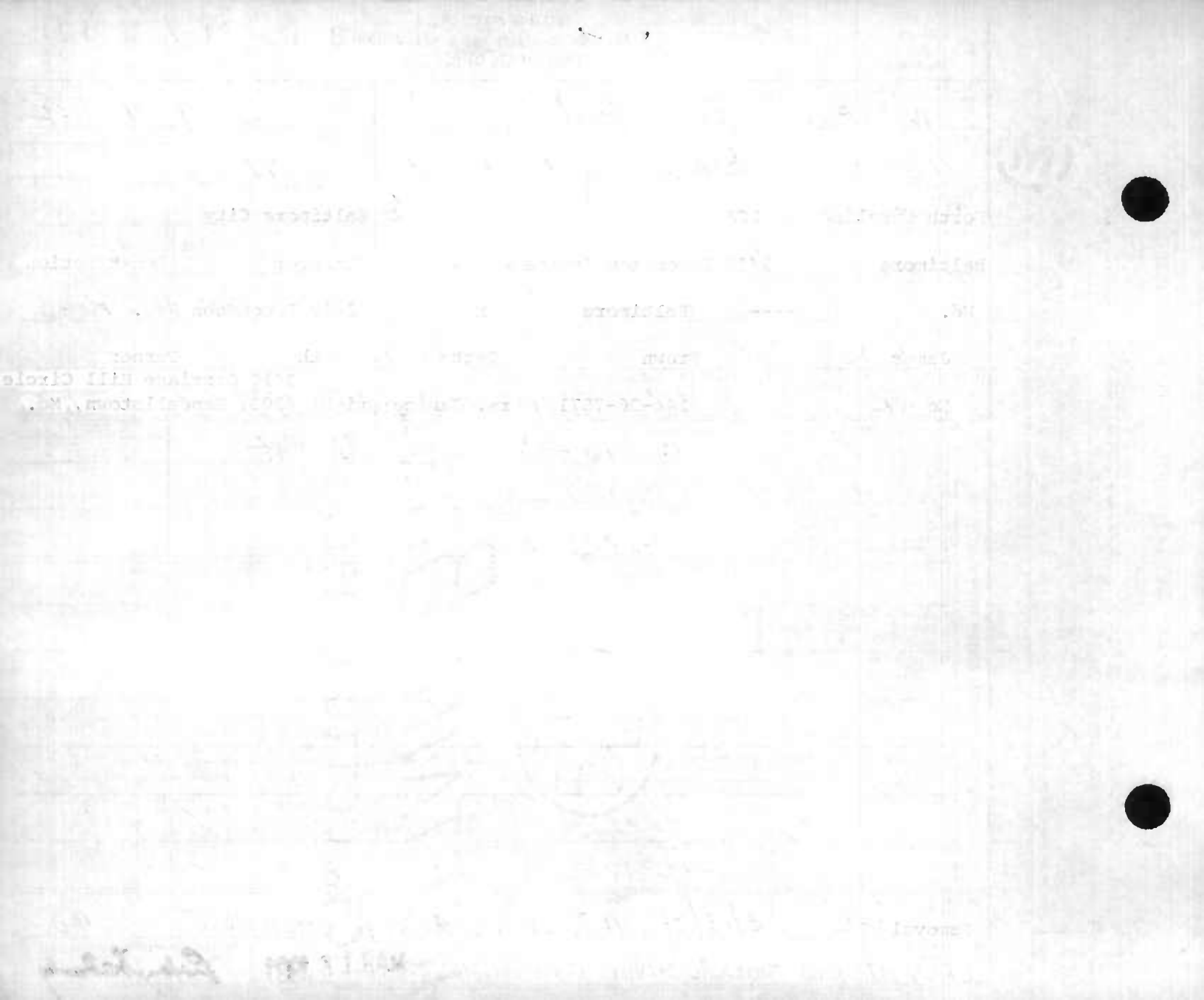
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 7 0 6 8   |  |
|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| William R. Hill  |  |  |  | 3 7 81  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| male   |  | Negro  |  | 1 1 04  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) MONTHS DAYS HOURS MIN.  |  |
| MARYLAND   |  | USA  |  | 77 YRS.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore  |  | PROVIDENT HOSPITAL   |  | Baltimore City MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
|  |  |  |  |   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  |
| Md.  |  |  |  | ---   |  |
| 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| Baltimore  |  |  |  | 2106 ALLENDALE ROAD   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |
| UNK  |  |  |  | UNK   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |
| UNK  |  |  |  | 256-07-2727   |  |
| 17. INFORMANT  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |
| PEARL COLE 194 MagaThy Beach Rd.   |  |  |  | 0389 Cardio - Pulmonary Arrest  |  |
|  |  |  |  | Sepsis  |  |
|  |  |  |  | 7x(R) femur   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-1 19 80 to 3/7 19 81, that (I) (we) lost saw the deceased alive on 3/7 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR   |  |
| William Rutledge   |  | 2600 Liberty Heights   |  | 3/7/81  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| BURIAL   |  | 3/13/81  |  | MT. ZION CEMETERY   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| LEROY HARRIS FUNERAL Service   |  | 4520 PenLucy   |  | MAR 16 1981   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 7 0 6 9  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | CERTIFICATE OF DEATH   |  |
| REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LAURIE C. HILTON</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> / DAY <b>14</b> / YEAR <b>81</b>                 |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> - DAY <b>1</b> - YEAR <b>1904</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.                                       |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Jack C.</b> MIDDLE <b>Hilton</b> LAST <b>Smith</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emelyn</b> MIDDLE <b>G.</b> LAST <b>Brown</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Architect</b>    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>577-07-5436A</b>  |  | 17. INFORMATION ADDRESS<br><b>Joyce Hommerbocker 314 Marcus Ave.</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, ? etiol</b><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2/27</b> , 19 <b>81</b> , to <b>3/14</b> , 19 <b>81</b> , that (we) last saw the deceased alive on <b>3/14</b> , 19 <b>81</b> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.) |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R Maggin</b>  |  | DEGREE <b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/14/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R MAGGIN</b>   |  | 22e. ADDRESS<br><b>MERCY HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>burial</b>   |  | 23b. DATE<br><b>3/18/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Broad Creek Oxon Hill</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>C. A. ...</b> ADDRESS <b>901 Hollins St</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McBrady</b>                                   |  |



17 1018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 7 0

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>REBECCA</b>   |  | FIRST MIDDLE LAST <b>HINDLIN</b>   |  | <b>3/30/81</b>  |  | <b>1230<sup>PM</sup></b>  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 1, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEVINDALE HEBREW HOME</b>            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>APT. 805</b>   |  | 13f. STREET ADDRESS<br><b>2500 W. BELVEDERE AVE.</b>   |  | 13g. CITY OR TOWN<br><b>#21215</b>  |  | 13h. STATE<br><b>MD.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISADORE EDISS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VICTORIA UNKNOWN</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>102-07-1629D</b>   |  |
| 16c. INFORMANT<br><b>MRS. YVETTE HEYMAN</b>  |  | 16d. ADDRESS<br><b>7510 PRINCE GEORGE RD.</b>  |  | 16e. CITY OR TOWN<br><b>#21208</b>  |  | 16f. STATE<br><b>MD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CEREBROVASCULAR ACCIDENT</b><br>427.3<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>THROMBOEMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATRIAL FIBRILLATION</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>immediate</b><br><b>years</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>OLD CVA</b> |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                               |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. SIGNATURE<br><b>Wm Wm</b>   |  | 22b. DATE SIGNED<br><b>3/30/81</b>   |  | 22c. DATE SIGNED<br><b>3/30/81</b>  |  | 22d. ADDRESS<br><b>Levin Dale Gerstner 21215</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL/BURIAL</b>  |  | 23b. DATE<br><b>3/31/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>UNITED HEBREW CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>STATEN IS. NEW YORK</b>                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  | 24b. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>  |  |

BP

DHMH-16 30M 2/80  
(VRA 15, 4)



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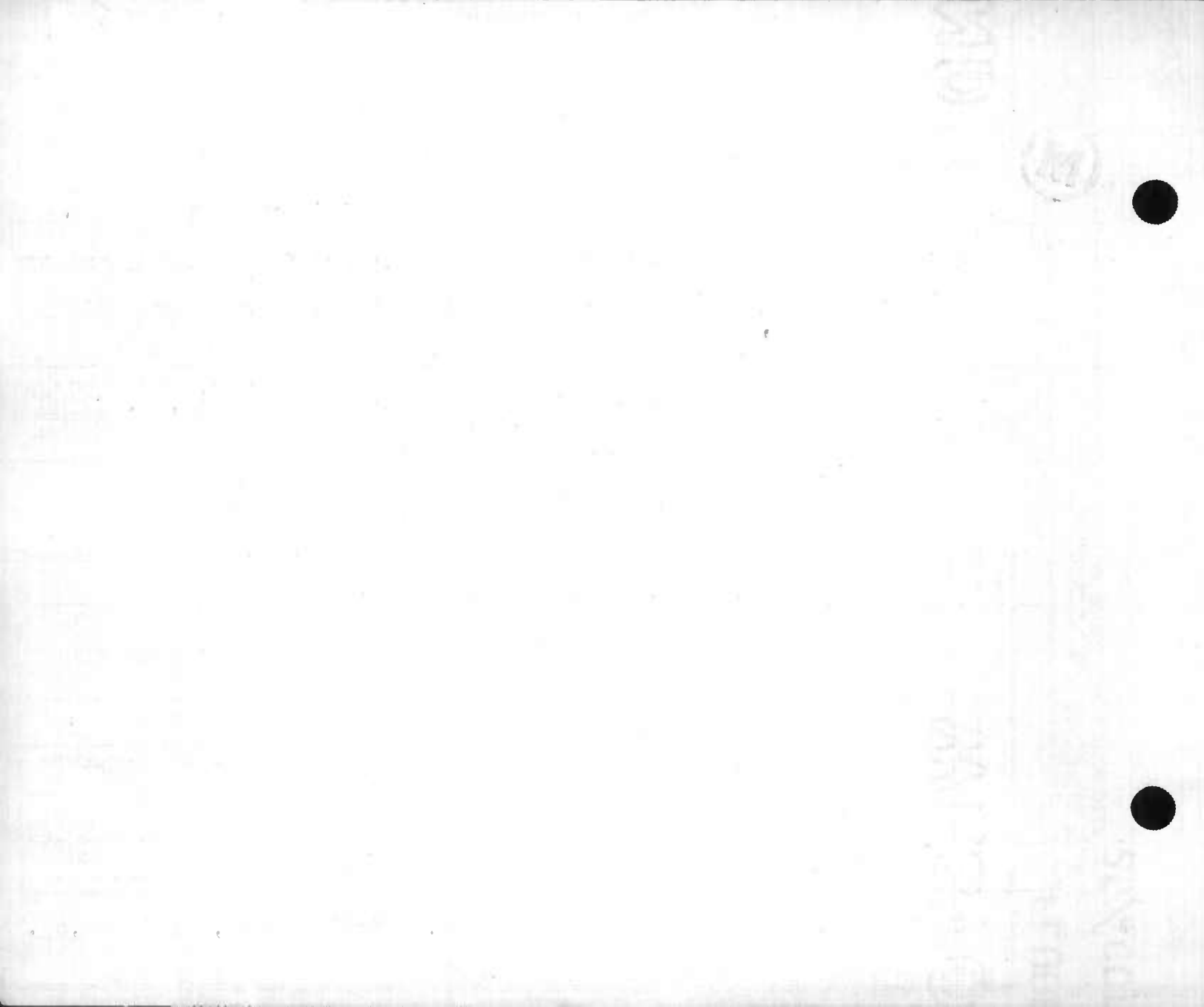
10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |   |  |                                      |   |  |
|--|--|--|---|--|--|---|---|--|--------------------------------------|---|--|
| 1- FOR STATE REGISTRAR   |  |  |   |  | REG. NO.   |   |   |  |                                      |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR  |   |   |  |                                      | 2b HOUR   |  |
| CLARA Emeline HINES  |  |  |   |  | MARCH 22, 1981   |   |   |  |                                      | 9:20p M   |  |
| 3 SEX  |  | 4 RACE   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN         |  | 7 IF UNDER 1 YEAR<br>IF UNDER 24 HRS |   |  |
| Female   |  | White  |   | 05 05 1906   |  |   | 74 YRS  |  |                                      |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9 BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                      |   |  |
| North Carolina   |  | USA  |   |  |  |   | Baltimore City MD   |  |                                      |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY     |   |  |
| Baltimore  |  | Church Hospital  |   |  |  |   | Technician  |  | Martin Marietta                      |   |  |
| 13a STATE  |  |  |   |  | 13b CITY OR TOWN   |   | 13c STREET ADDRESS  |  |                                      |   |  |
| Maryland   |  |  |   |  | Baltimore  |   | 36 Blister Street 21220   |  |                                      |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                 |   |   |  |                                      |   |  |
| James Smith  |  |  |   |  | Flora Baxley   |   |   |  |                                      |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |   |  | 16b SOCIAL SECURITY NO.  |   | 17 INFORMANT ADDRESS  |  |                                      |   |  |
| No   |  |  |   |  | 217-12-0431  |   | James Thrower 1907 Hackamore Lane<br>Alexandria, Va. 22308      |  |                                      |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST FROM HYPOTENSIVE SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RUPTURED AORTIC GRAFT INTO DUODENUM WITH</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>MASSIVE BLEEDING</u><br>(c) _____                           |  |  |   |  |  |   |   |  |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |   |  |                                      |   |  |
| 1. DIVERTICULUM OF THE COLON 2. MULTIPLE SMALL BAND ADHESIONS  |  |  |   |  |  |   |   |  |                                      |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?  |   | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                                      |   |  |
| 3-22-81  |  |  | MASSIVE GASTROINTESTINAL BLEEDING                                     |  |  | NO  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                      |   |  |
| 21a ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                      |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                                      |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-15-81</u> , 19 <u>81</u> , to <u>3-22</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |   |  |  |   |   |  |                                      |   |  |
| 22b SIGNATURE  |  |  |   |  | 22c DATE SIGNED  |   |   |  |                                      |   |  |
| Sompall Prasad   |  |  |   |  | 3-22-81  |   |   |  |                                      |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  | 22e ADDRESS  |   |   |  |                                      |   |  |
| SOMPALL PRASAD, M.D.   |  |  |   |  | CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY, BALTIMORE, MARYLAND 21231 |   |   |  |                                      |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                        |                                      |   |  |
| Burial   |  |  | 3/25/81   |  | Holly Hill Cem.  |   |   | Middle River, Baltimore, Md.                                     |                                      |   |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |  |   |  | 25a DATE REC'D. BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE                                       |  |                                      |   |  |
| Lassahn Funeral Home   |  |  |   |  | 7401 Belair Road   |   | MAR 30 1981   |  |                                      |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |  |  | 8107072   |  |
|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DANIEL HITE</b>   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-12-81</b>                             |  | 2b. HOUR<br><b>10<sup>00</sup> P.M.</b>   |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>CAUC</b>   | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Sept 10 1899</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS                                |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>APT. 1006 - 1 E. CHASE ST.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OR WORKING LIFE)<br><b>RETAIL</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL HITE</b>  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>RIFKA FORMAN</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>578-46-5350</b>   |  | 17 INFORMANT MRS. HELEN COVINS<br><b>6802 WESTBROOK RD. BALTO., MD 21215</b>   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>(1) Arteriosclerotic Cardiovascular Disease</b><br><b>429.2</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Discure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>(2) Essential Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr 5</b><br><b>yr 3</b> |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>July 9</b> 19 <b>80</b> , to <b>March 12</b> 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>Feb 5</b> 19 <b>81</b> and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>M. Alevizatos, MD</b>  |   | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/13/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.C. ALEVIZATOS, MD</b>   |   | 22e. ADDRESS<br><b>301 S. Paul Place Baltimore</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>3/15/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAR ZION TIFERETH ISRAEL ROSEDALE BALTO. MD</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD 21202</b>  |
| 24 FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |   | 24b. ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO. MD 21215</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1981</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |                             |  |  |  |  | REG. NO. 07073  |  |
|--|-------------------------|---|---|---|-----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ephraim (Ephriam) Wesley Hobbs Sr.</b>  |                         |   |   |   |                             |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3 19 19 81</b> |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 13 09</b>   | 6. AGE (IN YEARS) LAST BIRTHDAY YRS.<br><b>72</b> | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br><b>3 19 19 81</b>  |  | 2d. HOUR<br><b>6:35</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>2202 Druid Hill Ave.</b>             |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Monroe Hobbs</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ethel Porter</b>   |                             |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>579-05-9823</b>  |   | 17. INFORMANT ADDRESS<br><b>Ephraim W. Hobbs Jr 2400 Brookfield Ave</b>   |                             |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound to chest (unspecified weapon)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |   |   |                             |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |   |   |                             |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                             |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |   | 21b. TIME OF INJURY HOUR * MONTH DAY YEAR<br><b>6:05 P.M. 3 19 19 81</b>  |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |                             | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1301 W. North Ave. Balto. MD.</b>               |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                             |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |                         |   |   | TITLE (SPECIFY) M.D. <b>Assistant</b>   |                             |  |  | DATE SIGNED <b>3/20/81</b>                                     |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |                         |   |   | ADDRESS <b>111 Penn St. Balto., MD.</b>   |                             |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |                         |   |   | 23b. DATE<br><b>3/25/81</b>   |                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |                         |   |   |   |                             | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |



MAR 2 1961

Handwritten signature or scribble.

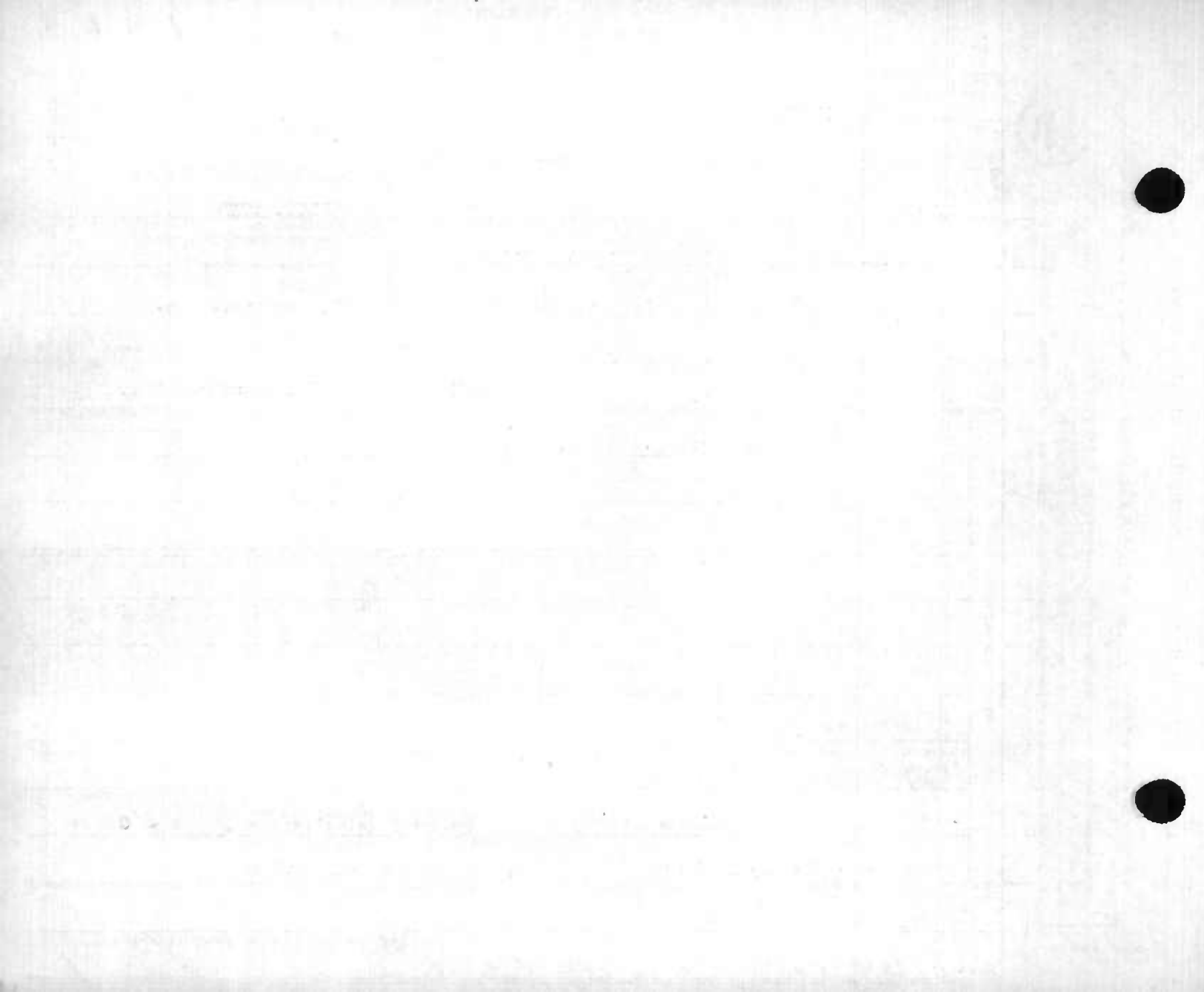
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 8 1 0 7 0 7 4  |  |
|---|--|--|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>KATIE HODGES</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 3 81</b>                     |  | 2b. HOUR<br><b>2:30 PM</b>   |
| 3 SEX<br><b>FEMALE</b>  | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 3 81</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.<br><b>30</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE 11F NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br><b>MARYLAND</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTO. CITY</b>                               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN HODGES</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>VANCENE BURNETTE</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><b>MOTHER 710 Beaumont Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PREMATURITY</b><br><b>7651</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____    |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/3</b> , 19 <b>81</b> , to <b>3/3</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/3</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Susan V. Previas MD</b>  |  | DEGREE   |   | 22c. DATE SIGNED<br><b>3/03/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUSAN PREVIAS, MD.</b>  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL</b>   |  | 23b. DATE<br><b>3-19-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ANATOLY B.B. OF MD.</b>   |  | ADDRESS<br><b>BALTO, MD</b>  |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>MARCH 3 1981</b>   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

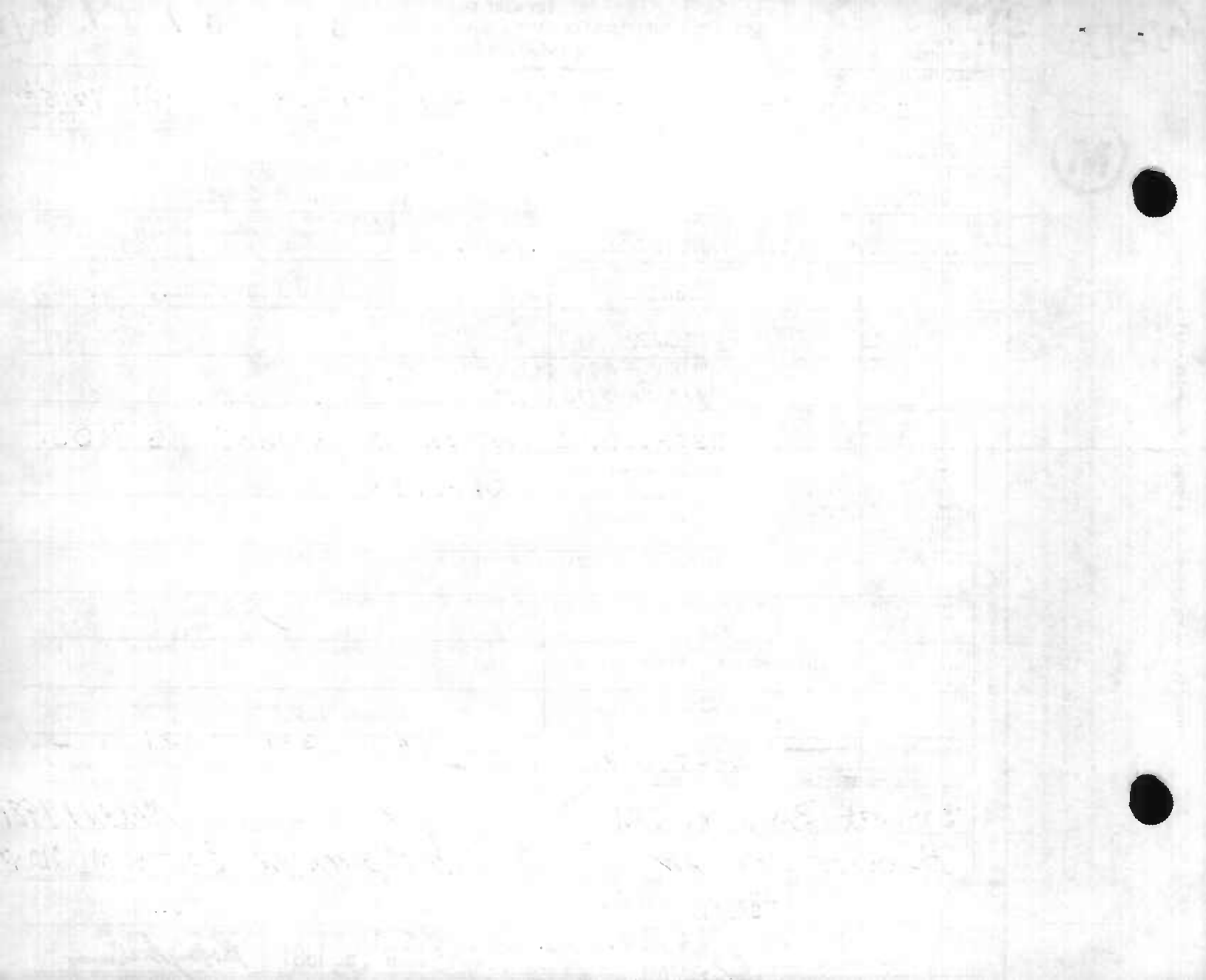
8 1 0 7 0 7 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |   |  |  |   |  |                              |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERTRUDE</b>   |  |  | FIRST <b>HOFFBERGER</b>  |  |  | LAST  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 1, 1981</b>  |  |  | 7b. HOUR<br><b>10:15A.</b>                                    |  |                              |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 22, 1895</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  | IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7111 PARK HEIGHTS AVE., APT. 902</b> |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>           |  |                              |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>7111 PARK HTS. AVE., APT. 902</b>   |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS MILLER</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH MANKOWITZ</b>   |  |  |   |  |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>220-20-5136</b>   |  |  | 17. INFORMANT<br><b>MRS. LOIS BLUM</b>  |  |  | ADDRESS<br><b>3310 FALLSTAFF RD. BALTO. MD. 21215</b>   |  |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1889 METASTATIC CANCER OF URINARY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>BLADDER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 MOS.</b> |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |   |  |  |   |  |                              |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-27-81</b> to <b>3-1-81</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-27-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |   |  |                              |  |
| 22b. SIGNATURE<br><b>Barnett Berman M.D.</b>  |  |  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>MARCH 1, 1981</b>   |   |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARNETT BERMAN</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>3119 NORTHBROOK RD. BALTO. MD 21208</b>  |  |  |   |  |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>3/2/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |   |  |  |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1981</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |   |  |                              |  |
| 6010 REISTERSTOWN RD. BALTO. MD. 21215  |  |  |  |  |  |   |  |  |   |  |  |   |  |                              |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 0 7 6  
CERTIFICATE OF DEATHFOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH G HOFFMAN              |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 2 81   |  | 2b. HOUR<br>15<br>12 P.M.                                       |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB 08 1981   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 29                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br>VIRGINIA   |   | 13b. CITY OR TOWN<br>HERNDON  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>1207 MOSBY COURT                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE HOFFMAN             |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LINDA  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT ADDRESS                                      |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

7707

DUE TO, OR AS A CONSEQUENCE OF

(b) Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c) Congenital

Hydrocephalus

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

15 days

22 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION


|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from February 26, 19 81, to March 2, 19 81, that (I) (we) last saw the deceased alive on March 2, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22a. SIGNATURE<br>Michael A. Simmons  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>3/2/81   |   |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL A. SIMMONS M.D.  |  | 22e. ADDRESS<br>THE JOHNS HOPKINS HOSPITAL                             |  |  |   |

|  |                           |   |   |
|--|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION                        | 23b. DATE<br>MAR 03, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>JOHNS HOPKINS | 23d. LOCATION<br>BALTIMORE COUNTY MD.     |
| 24. FUNERAL DIRECTOR<br>NAME THE JOHNS HOPKINS Hospital - Baltimore, Md. ADDRESS |                           | 25a. DATE RECEIVED BY REGISTRAR<br>MAR 16 1981      | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 333-2222.



10

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 81 07077  |                                       |
|--|--|--|--|---|---------------------------------------|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |                                       |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>M. Louise HOGAN</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MAR 18 81</b> 2b. HOUR<br><b>11:05 P.M.</b> |   |                                       |
| 3 SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 27, 1887</b>   |                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                                       |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Keswick 720 W. 40th Street 2211</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |                                       |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                               |   |                                       |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Patrick Quigley</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Margaret Walsh</b>                |   |                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220 44 5067</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. J. Leo Flanigan, Balto., Md.</b>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |  |  |  |   |                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |                                       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |                                       |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br><b>8 Aug 78 to 18 Mar 81</b>                                   |                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>18 Mar 81</b> saw the deceased alive on <b>18 Mar 81</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If I) (we) (did) (did not) view the body after death.   |  |  |  |   |                                       |
| 22b. SIGNATURE <b>Dr. Aubrey D. Richardson</b> DEGREE <b>M.D.</b>  |  |  |  | 22c. DATE SIGNED<br><b>18 Mar 81</b>  |                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Aubrey D. Richardson, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Keswick Home, Balto., Md.</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/21/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |                                       |
| 23d. LOCATION CITY OR TOWN<br><b>Balto.,</b>   |  | COUNTY<br><b>Md.</b>   |  | STATE   |                                       |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>   |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |                                       |

BP.

4502 York Road, Balto., Md. 21212  
 Henry W. Jenkins & Sons Co.  
 New Cathedral Balto., Md.  
 Dr. Aubrey D. Richardson, M.D., Kewick Home, Balto., Md.

No  
 Patrick  
 Maryland  
 230 44 2067  
 Mrs. J. Leo Flanagan, Balto., Md.  
 Guidley  
 Margaret  
 Walsh  
 4000 N. Charles Street  
 Homemaker  
 Own Home  
 New York  
 U.S.  
 White  
 For 1st  
 For 1st, 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |   |   |   |   |  | 8  | 1 | 0                             | 7                                 | 0                       | 7 | 8      |
|--|--|--|--|--|---|---|---|---|--|--|---|-------------------------------|-----------------------------------|-------------------------|---|--------|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  |   |   |   |   |  | REG. NO.   |   |                               |                                   |                         |   |        |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary M. Hogg</b>  |  |  |  |  |   |   |   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/16/81</b>                                |   |                               |                                   | 2b. HOUR<br><b>6:10</b> |   | P<br>M |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 5 1889</b>   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN. |                                   |                         |   |        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |   |                               |                                   |                         |   |        |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Convalesarium</b> |  |   |   |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   |                               | 12b. KIND OF BUSINESS OR INDUSTRY |                         |   |        |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |   |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>25 S. Curley St.</b>                                       |   |                               |                                   |                         |   |        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Gier</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Doberneck</b>  |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Lillian Weidner 204 S. East Ave.</b>  |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCA</b><br>(c) <b>ASCVD</b>                |  |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |                               |                                   |                         |   |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>SENILE DEMENTIA</b>   |  |  |  |  |   |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |                               |                                   |                         |   |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/9/76</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 22a. I certify that (i) (this hospital) attended the deceased from <b>10/9/76</b> 19____ to _____ 19____, that (f) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not) (do) (did) not view the body after death. |  |  |  |  |   |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 22b. SIGNATURE<br><b>Luis E. Rivera</b>  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   |   |   | 22c. DATE SIGNED<br><b>3/18/81</b>   |  |   |                               |                                   |                         |   |        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luis E. Rivera, M.D.</b>   |  |  | 22e. ADDRESS<br><b>50 Scott Adam Road<br/>Cockeysville, Maryland 21030</b>   |  |   |   |   |   |  |  |   |                               |                                   |                         |   |        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/19/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore</b> MD.                              |  |  |   |                               |                                   |                         |   |        |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>  |  |  |  |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 20 1981</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. J. McCreedy</b>  |  |   |                               |                                   |                         |   |        |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07079

FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|-------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Jane  |  |  | MIDDLE<br>Hokes   |  |  | LAST<br>Hokes  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR  |  |  |                   |  |  |
| 1. SEX<br>female  |  |  | 4. RACE<br>black   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 16 26   |  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) YRS.<br>55                                      |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 14 81                               |  |  | 2d. HOUR<br>11:06 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                               |  |  | am  |  |  | MD.   |  |  |                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3520 Virginia Avenue |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |   |  |  |                   |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>3520 Virginia Ave  |  |  |   |  |  |                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James G Lee   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia P. Hamlett   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>235-42-1458  |  |  | 17. INFORMANT<br>Vicie Lewis  |  |  | ADDRESS<br>3520 Virginia Ave.  |  |  |   |  |  |   |  |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |                   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |  |  |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |  |  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| ACTUAL SIGNATURE<br><u>H. R. Guard</u>  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  | MEDICAL EXAMINER  |  |  | DATE SIGNED<br>3/15/81   |  |  |   |  |  |   |  |  |                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3/19/81   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                             |  |  |   |  |  |   |  |  |                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Charles H. Powell   |  |  | ADDRESS<br>319 N. Schroeder St   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |  |   |  |  |   |  |  |                   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

MAR 16 1981

Handwritten signature or initials at the bottom left corner.

Handwritten text at the bottom center, possibly a date or reference number.

Handwritten mark or symbol on the left margin.

Vertical text on the left margin, possibly a page number or document identifier.

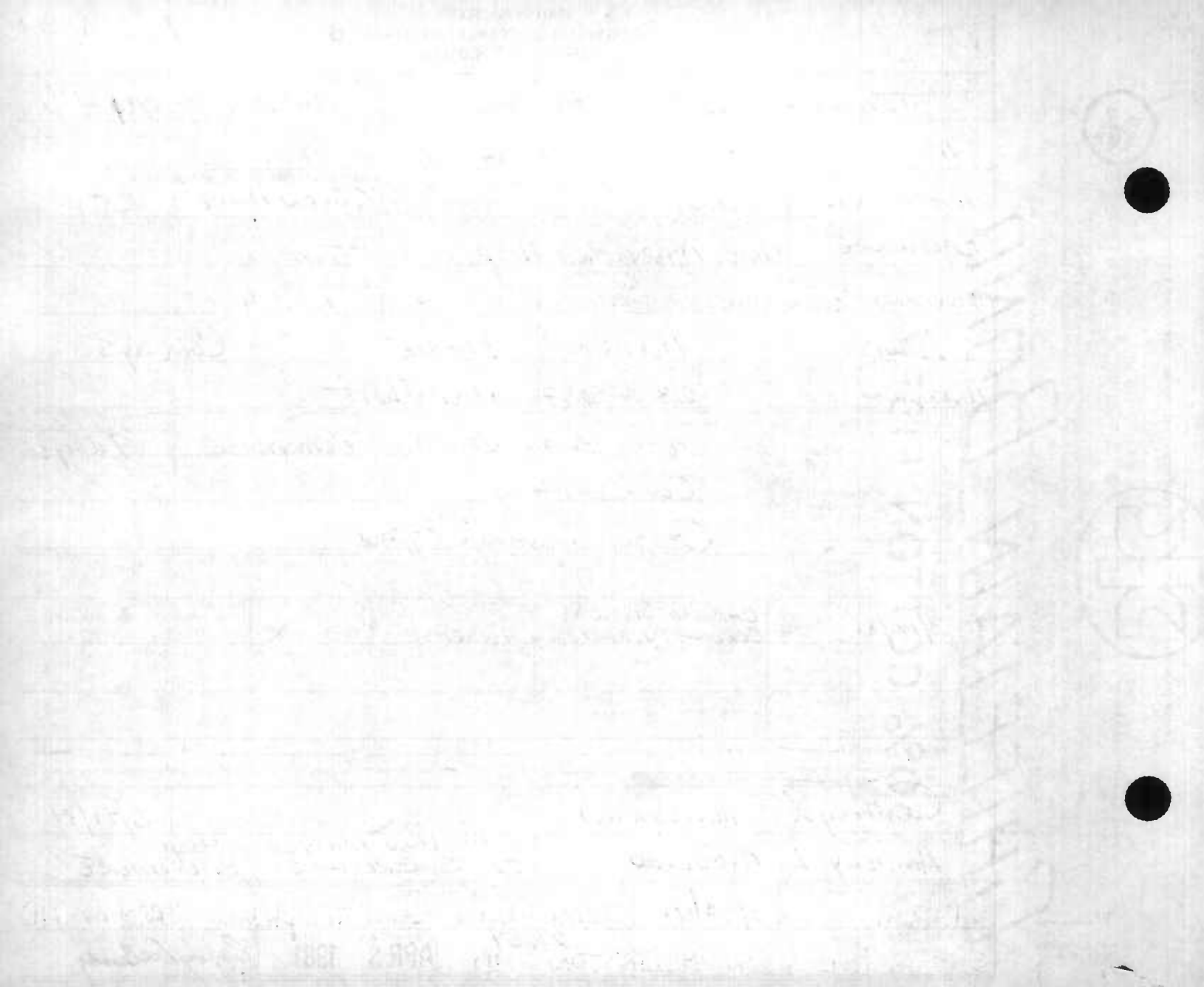
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 0 7 0 8 0  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANKLIN NMI HOLDEN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 21 1981</b> 2b. HOUR <b>4<sup>18</sup> P<sup>M</sup></b>  |  |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07 14 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. MARYLAND Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FARMER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>QUEEN ANNE'S</b>  |  | 13c. CITY OR TOWN<br><b>CHESTERTOWN</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>LEWIS HOLDEN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>BESSIE CONEGYS</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-5697</b>  |  |
| 17. INFORMANT<br><b>Hosp Chart</b>  |  | ADDRESS   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ANOXIC BRAIN DAMAGE, HEMORRHAGE</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>COAGULOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARDIOPULMONARY BYPASS</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b><br>"<br>"   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>3/12/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CAROTID STENOSIS CORONARY ARTERY DISEASE</b>                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Anthony L. Moulton MD</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/21/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANTHONY L. MOULTON</b>  |  |   |  | 22e. ADDRESS<br><b>UNIV. MARYLAND Hosp 22. S GREENE ST., BALTIMORE</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/24/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Templeville Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Templeville CAROLINE MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EDW. FELLOWS &amp; SON MILLINGTON MD 21651</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 3 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 1 0 7 0 8 1         |  |
|---|--|---|---|-----------------------|--|
| 1- STATE REGISTRAR  |  | CERTIFICATE OF DEATH  |   |                       |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a DATE OF DEATH  |   | 2b HOUR               |  |
| Letha M. Holderby   |  | March 4, 1981   |   | M                     |  |
| 3 SEX   | 4 RACE   | 5 DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                | 7 UNDER 1 YEAR        |  |
| Female  | White  | Dec. 23, 1895   | 85  | MONTHS DAYS HOURS MIN |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                           |                       |  |
| West Virginia   | USA  |   | Baltimore City MD.  |                       |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b KIND OF BUSINESS OR INDUSTRY                              |                       |  |
| Baltimore 21206   | Belair Convalesarium Nursing Home  | Housewife   | Home  |                       |  |
| 13a STATE   | 13b CITY OR TOWN   | 13c INSIDE CITY LIMITS?   | 13d STREET ADDRESS  |                       |  |
| Maryland  | Baltimore  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 4 Altimeter Ct. 21220   |                       |  |
| 14 FATHER'S NAME  | 15 MOTHER'S MAIDEN NAME  | 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |   |                       |  |
| Mark Adams  | Ann Flowers  | No  |   |                       |  |
| 17 INFORMANT  | 18 SOCIAL SECURITY NO.   |   |   |                       |  |
| Bobbie Holderby   | 234-16-8397  |   |   |                       |  |
| 19 ADDRESS  |  |   |   |                       |  |
| 556 Compass Road 21220  |  |   |   |                       |  |
| 19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COPD   |  |   |   |                       |  |
| 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CHF   |  |   |   |                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |                       |  |
| Senile Dementia   |  |   |   |                       |  |
| 19a DATE OF OPERATION   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a AUTOPSY?  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                       |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                       |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |                       |  |
|   | P.M. 19  |   |   |                       |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     | 21f LOCATION STREET   | CITY OR TOWN  | COUNTY                | STATE  |
|   |  |   |   |                       |  |
| 22a I certify that (I, (this hospital) attended the deceased from Feb 19 81, to March 4, 19 81, that (I, (we) last saw the deceased alive on Mar 3, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I, (we) (did) (did not) view the body after death. |  |   |   |                       |  |
| 22b SIGNATURE   | DEGREE   | 22c DATE SIGNED   |   |                       |  |
| Howard H. Bond  | MD ATTENDING PHYSICIAN   | March 5, 1981   |   |                       |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e ADDRESS  |   |   |                       |  |
| Howard H. Bond, M.D.  | 9618 Belair Road, Perry Hall, Md.  |   |   |                       |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b DATE   | 23c NAME OF CEMETERY OR CREMATORY   | 23d LOCATION CITY OR TOWN                                     | COUNTY                | STATE  |
| Burial  | 3-7-81   | Gardens of Faith Cem.   | Baltimore County  |                       | Maryland                                     |
| 24 FUNERAL DIRECTOR   | 25a DATE REC'D. BY REGISTRAR   | 25b REGISTRAR'S SIGNATURE   |   |                       |  |
| Brazdzinski Funeral Home  | MAR 6 1981   |   |   |                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

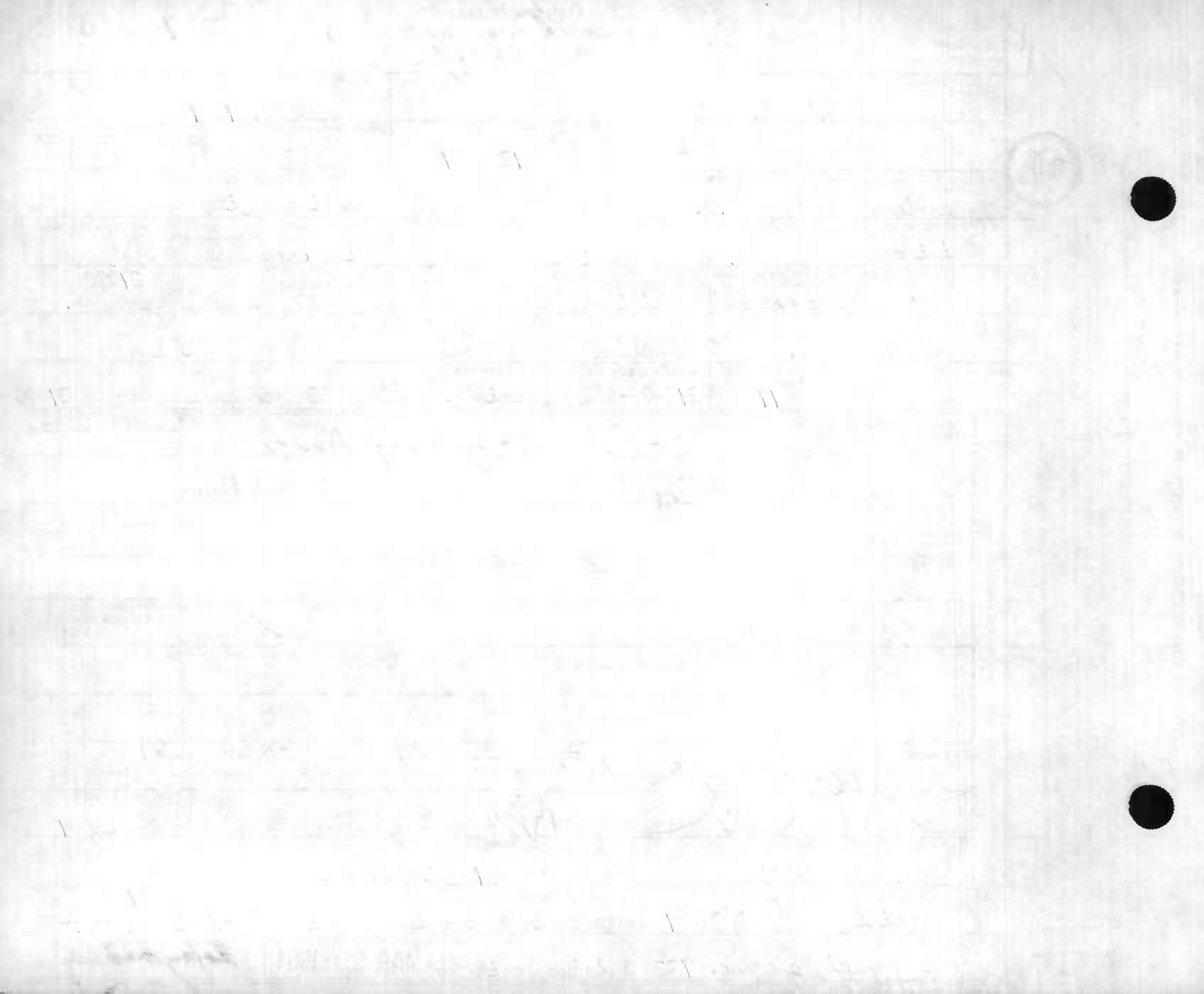
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                                    |  | 8 1 0 7 0 8 2 |   |   |
|--|--|---|------------------------------------|--|---------------|---|---|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   | REG. NO.                           |  |               |   |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Stanley R. Holler  |  |   | 2a DATE OF DEATH<br>March 26, 1981 |  | 2b HOUR<br>M  |   |   |
| 3 SEX<br>M   |  | 4 RACE<br>White   |                                    | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>8 12 15   |               | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS                       |   |
| 7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.   |                                    | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                                    | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>line crew supv  |               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bg&F   |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>Md.  |  | 13c COUNTY<br>Anne Arundel  |                                    | 13d CITY OR TOWN<br>Baltimore  |               | 13e STREET ADDRESS<br>226 Hammonds Ferry Rd. 21090  |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles L. Holler   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Smith  |                                    | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   |               |   |   |
| 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-05-5827   |  | 17 INFORMANT ADDRESS<br>Doris E. Holler 226 Hammonds Ferry Rd 21090   |                                    |  |               |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE 1a) 4140 CAR Di. Resp. Tng Arter<br>DUE TO, OR AS A CONSEQUENCE OF<br>1b) Arterio-sclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>1c)   |  |   |                                    |  |               |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a)   |  |   |                                    |  |               |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |               |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |               |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from 2/29/81 to March 26, 1981, that (I) (we) lost<br>saw the deceased alive on May 23, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |                                    |  |               |   |   |
| 22b SIGNATURE<br>Dr. Glen Robbins  |  | DEGREE<br>MD  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |               | 22c. DATE SIGNED<br>26 Mar 81   |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Glen Robbins   |  | 22e ADDRESS<br>714 Ticondaroga  |                                    |  |               |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/30/81  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial   |               | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey, Howard Maryland  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home Inc.   |  | ADDRESS<br>1328 Sulphur Spring Rd   |                                    | 25a. DATE REC'D. BY REGISTRAR<br>MAR 30 1981   |               | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |





**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PEBBLETON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M 2/80

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  | 07083   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH                                     |  | 2b. HOUR  |  |
| FIRST MARY, MIDDLE HOLLY, LAST  |  |   |  |   |  | 2c. DATE OF ESTIMATION                                      |  | 2d. HOUR  |  |
| 3. SEX<br>female  |  | 4. RACE<br>black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                             |  | 7. IF UNDER 1 YR. IF UNDER 24 HRS.                          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City     |  | 12. MD.   |  |
| 13. CITY OR TOWN OF DEATH<br>Baltimore  |  | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>Lutheran Hospital                           |  | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 16. KIND OF BUSINESS OR INDUSTRY                            |  |   |  |
| 17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE Maryland   |  | 17b. COUNTY Balto.  |  | 17c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 17d. STREET ADDRESS<br>517 N. Mount St.                     |  |   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Baynor   |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillie Baynor  |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 21. SOCIAL SECURITY NO.                                     |  | 22. INFORMANT ADDRESS<br>Carrie Carter 3510 W. Franklin St. |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease<br>4029 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  | 24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |
| 25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |   |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 35. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |   |  |
| 36. ACTUAL SIGNATURE<br>Margarita A. Korell   |  | 37. TITLE (SPECIFY)<br>M.D. Assistant   |  | 38. MEDICAL EXAMINER  |  | 39. DATE SIGNED<br>3-12-81                                  |  |   |  |
| 40. EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  | 41. ADDRESS<br>111 Penn Street  |  |   |  |   |  |   |  |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 43. DATE<br>3/17/81   |  | 44. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat. Cem.   |  | 45. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |   |  |
| 46. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett  |  | 47. ADDRESS<br>4600 Liberty Heights Ave   |  | 48. DATE REC'D. BY REGISTRAR<br>MAR 16 1981   |  | 49. REGISTRAR'S SIGNATURE<br>Leroy O. Dyett                 |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 1 0 7 0 8 4  |  |   |  |
|--|--|---|--|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Daniel W. Holmes</b>   |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 2 81</b>  |  | 2b HOUR<br><b>330P</b>  |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>Negro</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 17, 1927</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Gas station</b>  |  |
| 13a STATE<br><b>Md.</b>  |  |   |  | 13b CITY OR TOWN<br><b>Baltimore</b>   |  | 13c STREET ADDRESS<br><b>5220 York Rd.</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Holmes</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mildred Holmes</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |
| 16b SOCIAL SECURITY NO.<br><b>328-24-1667</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Elsie Sturgis</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Poorly Differentiated Squamous Cell Carcinoma</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>of Esophagus               |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/2 81</b> to <b>3/2 81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/2 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b SIGNATURE<br><b>H. Cook MD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c DATE SIGNED<br><b>3/2/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. A. Cook MD</b>  |  | 22e ADDRESS<br><b>Balt City Hospital</b>  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>3-7-81</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Bethel Baptist</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Franktown Northampton Va.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Matthew Cornish</b>   |  | ADDRESS<br><b>F.B. Holland Memorial Cheriton, Va, 23316</b>   |  | 25a DATE REC'D BY REGISTRAR<br><b>MAR 10 1981</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Dorothy McQuay</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 7 0 8 5   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Holmes DOROTHY Holmes.</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>03 19 81</i>   |  | 2b. HOUR<br><i>750 A.M.</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>09 18 12</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington D.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Balto. City Hospitals</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>Maryland</i>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>William Harris</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Lara West</i>   |  | 13e. STREET ADDRESS<br><i>2000 Odell Avenue</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><i>Margaret Talbot - Same as above</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>GI Bleeding</i> <i>ASCD.</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>seconds</i><br><i>longstanding</i> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i)<br><i>Dementia, GI Bleeding, chronic Aspirations.</i>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/12/81</i> , 19 <i>81</i> , to <i>3/19</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>3/19</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Lamarcia Coon MD</i>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>3/19/81</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LAMARCIA COON MD</i>   |  | 22e. ADDRESS<br><i>Balto City Hosp, Ektown Ave, Balto, Md</i>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-23-81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>CHAS. A. RICE FSPA 1300 Eutaw Place</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 26 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barbara K. Brady</i>   |  |

BP

CONFIDENTIAL

TO : DIRECTOR, FBI  
FROM : SAC, [illegible]  
SUBJECT: [illegible]

RE: [illegible]

[illegible]

[illegible]



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-1

07086

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROSALIE R. HOLMES</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 25, 1981</b> |   | 2b. HOUR<br><b>4:40</b><br>M   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 20, 1886</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>631 Deepdene Road</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander H. Rutherford</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosa Seddon</b>   |  | 16. STREET ADDRESS<br><b>631 Deepdene Road</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216 14 7550</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>A. Rutherford Holmes, Md.</b>  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br><b>4409</b><br>IMMEDIATE CAUSE (a): <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST:<br>DUE TO, OR AS A CONSEQUENCE OF:<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION:<br>CITY OR TOWN COUNTY STATE<br><b>1957 25 March 81</b>  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>22 March 81</b> to <b>25 March 81</b> that (I) (we) last saw the deceased alive on <b>22 March 81</b> and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. William G. Helfrich</b>   |  | 22c. DEGREE<br><b>MD</b>  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  | 22e. DATE SIGNED<br><b>3/25/81</b>   |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. William G. Helfrich, M.D.</b>  |  | 22g. ADDRESS<br><b>5006 Roland Ave., Balto., Md.</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/27/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  | ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |



Henry W. Jenkins & Sons Co.

300 York Road, Baltimore, Md. 21218

1001 0 2 HAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 1.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   | 8 1 0 7 0 8 7  |                                   |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |   | 2b. HOUR   |                                   |
| THOMAS F HOLMES  |  | 03 11 81  |   | 0940P.M.   |                                   |
| 3 SEX  | 4. RACE  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   |
| Male   | Black  | 11 MONTH 2 DAY 19 17  |   | 63 YRS.  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |
| Tappahanna, Va.  | U.S.A.   |   |   | Baltimore, MD.   |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Balto.   | Bon Secours Hospital   |   | Bethlehem Steel   |  |                                   |
| 13a. STATE   |  |   |   |  |                                   |
| Maryland   |  |   |   |  |                                   |
| 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |                                   |
|  |  | Balto.  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |
| George   |  | Rebecca   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |
| Yes  |  | 218-01-7025   |   | Mrs. Gladys Holmes 2213 W. Saratoga St.  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:   |  |   |   |  |                                   |
| IMMEDIATE CAUSE (a) Terminal CA 2° CA of Colon   |  |   |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   |
|  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|  |  | P.M. 19   |   |  |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |                                   |
|  |  |   |   |  |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from 03/10, 19 81, to 03/11, 19 81, that (I) (we) last saw the deceased alive on 03/11, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |
| 22b. SIGNATURE   |  | DEGREE  |   | 22c. DATE SIGNED   |                                   |
| Kuang-Yen Huang M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 03/12/81   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |                                   |
| KUANG-YEN HUANG  |  | BON Secours Hospital  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial   |  | 3/16/81   |   | Arbutus Mem. Pk.   |                                   |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| LEROY O. DYETT   |  | 4600 Liberty  |   | MAR 16 1981  |                                   |
|  |  | Hotchkiss Ave.  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
|  |  |   |   | R. J. Kelly  |                                   |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |   |   |  |   |  |
|---|--|---|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas Holter</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 18 1981</b>                |  |  | 2b. HOUR<br><b>7:15 PM</b>  |   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Cauc.</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 13 1894</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>                                       |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Belair Nursing Home</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>504 N. Linwood Ave.</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Holter</b>  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flora Horsman</b>   |  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br><b>Evelyn Petri 504 N. Linwood Ave.</b>            |   |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a): <b>Acute Cardiac Failure / Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b): <b>Chronic Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c): <b>Arteriosclerotic Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>years</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):<br><b>Diabetes mellitus; Recurrent Pneumonia; Emphysema; repeated Transient Ischemic Attacks</b>   |  |   |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>11/30/1980</b> to <b>3/18/1981</b> , that (I) <del>we</del> last saw the deceased alive on <b>3/1/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did not) view the body after death.  |  |   |  |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Albert B. Bradley</b>  |  |   |  |  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>March 20, '81</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert B. Bradley, M.D.</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>4900 Belair Road Baltimore, Md. 21206</b>                      |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/21/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>                               |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |   |  |  |   | 8  | 1  | 0                              | 7                                       | 0                             | 8 | 9 |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|---|-------------------------------|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |   |  |  |   | REG. NO.   |  |                                |   |                               |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Moses Howell</b>   |  |  |   |  |  |   |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 31, 1981</b>             |  |                                |   | 2b. HOUR<br>M                 |   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>Negro</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 08</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS<br>HOURS MIN. |   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |                                |   |                               |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3110 Brighton St.</b> |  |  |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY       |                               |   |   |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3110 Brighton St.</b>  |                                |   |                               |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie Howell</b>   |  |  |   |  |  |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Boddie</b> |  |                                |   |                               |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-03-1093</b>  |  |  | 17. INFORMANT ADDRESS<br><b>Lucille Howell 3110 Brighton St.</b>  |  |  |   |  |  |                                |   |                               |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>with heart block.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension</b> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |                                |   |                               |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |  |   |  |  |   |  |  |                                |   |                               |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |   |                               |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |                                |   |                               |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |                                |   |                               |   |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3/2</b> , 19 <b>81</b> , to <b>3/31</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   |  |  |                                |   |                               |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Markus J. J. J.</b>   |  |  |   |  |  |   |  |  |   | DEGREE<br><b>MD</b>  |  |                                | 22c. DATE SIGNED<br><b>Mar 31, 1981</b> |                               |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. M. KRIEGER MD</b>   |  |  |   |  |  |   |  |  |   | 22e. ADDRESS<br><b>606 Hammond Lane Baltimore, Md. 21225</b>             |  |                                |   |                               |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>4/6/81</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. pk.</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |  |  |                                |   |                               |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |   |  |  |   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>                                     |  |                                | 25a. DATE REC'D. BY REGISTRAR           |                               |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>APR 01 1981</b> |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br>MILAN MILLER HUDGINS   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>3/21/81  |  |  |  |
| 3 SEX<br>male   |  |   |  | 2b HOUR<br>7:55am   |  |  |  |
| 4 RACE<br>caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>3/5/21  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS  |  | 7a UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7c CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S. Public Health Service Hospital |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sailor  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>U.S. Navy  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland  |  |   |  | 13b COUNTY<br>Baltimore   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Hue Trenton Hudgins   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>unknown  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes   |  |   |  | 16b SOCIAL SECURITY NO<br>1942-71   |  |  |  |
| 17 INFORMANT<br>U.S. Public Health Service Hospital   |  |   |  | ADDRESS<br>RECORDS-3100 Wyman Park Drive Balto., Md #11   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC CANCER (BRAIN)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>LARGE CELL CARCINOMA OF LUNG</u> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hours   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 2/28/ 19 81 to 3/21 19 81, that (I) (we) last saw the deceased alive on 2/27 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b SIGNATURE<br>C. Dickason, M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  | 22c DATE SIGNED<br>3/23/81   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cheryl Dickason, M.D.   |  |   |  | 22e ADDRESS<br>3100 Wyman Park Drive Baltimore, Maryland #11  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>03-26-81  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Crownsville Vet. Cem.  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville A.A. Maryland  |  |
| 24 FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc.  |  |   |  | ADDRESS<br>4107 Wilkens Ave.  |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 24 1981  |  |

MAR 2 1951

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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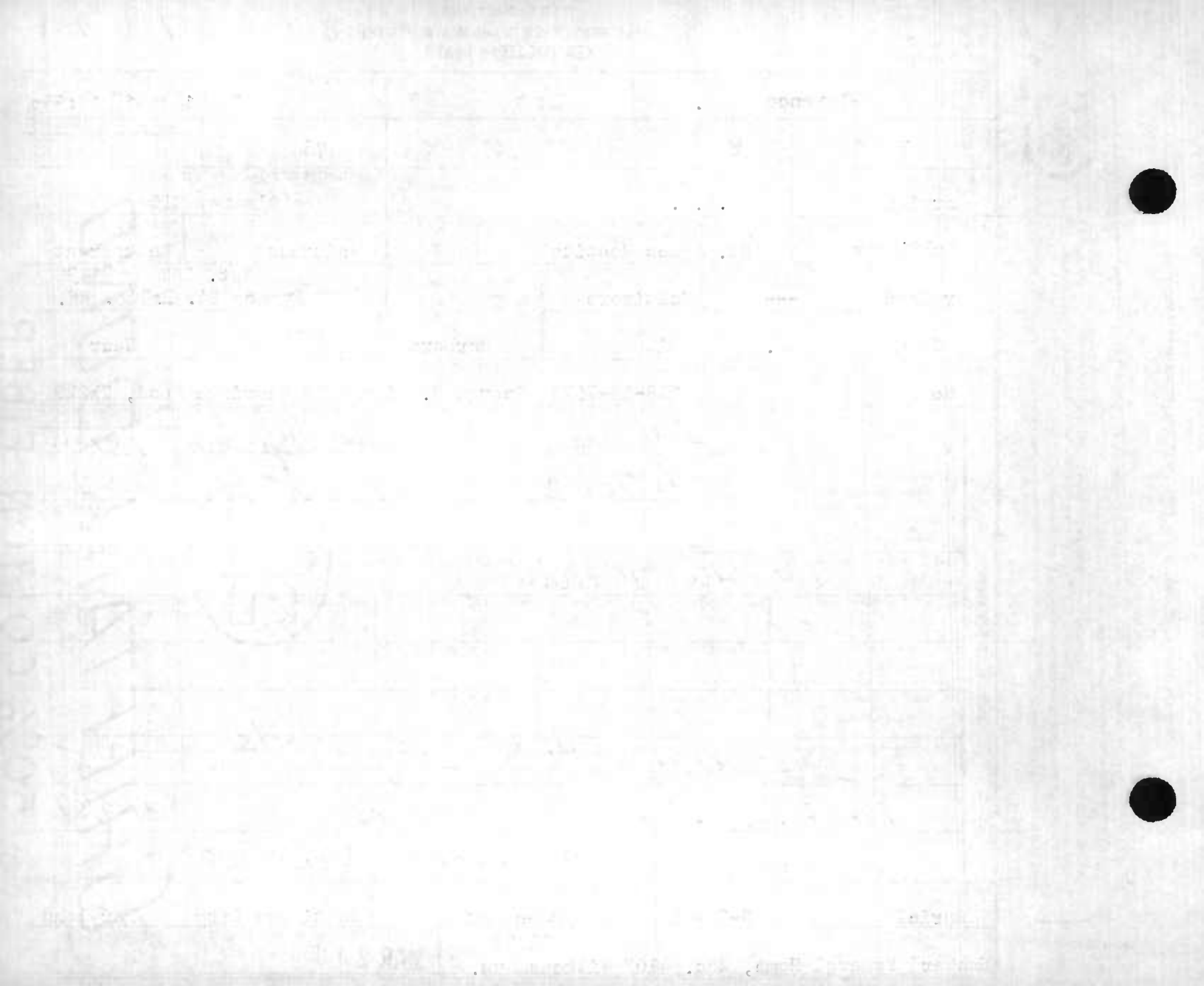
REG. NO.

|  |          |  |                   |  |                                      |  |  |          |
|--|----------|--|-------------------|--|--------------------------------------|--|--|----------|
| 1. FOR STATE REGISTRAR   |          | 2a. DATE OF DEATH  |                   | MONTH  | DAY                                  | YEAR   | 2b. HOUR                                     |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |          | FIRST  | MIDDLE            | LAST   |                                      |  |  |          |
| Florence C. Hunt   |          |  |                   |  | 3                                    | 18   | 81   | 11:39 PM |
| 3. SEX   | F        | 4. RACE  | W                 | 5. DATE OF BIRTH   | MONTH                                |  |  | DAY      |
|  |          |  |                   | 11   | 28                                   | 02   |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | Maryland | 7b. CITIZEN OF WHAT COUNTRY?   | U.S.A.            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |          |
| 10. CITY OR TOWN OF DEATH  |          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |          |
| Baltimore  |          | St. Agnes Hospital   |                   | Waitress   |                                      | Restaurant   |  |          |
| 13a. STATE   |          | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                  |  |  |          |
| Maryland   |          | ---  | Baltimore         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | Apt. 102 21230                       |  |  |          |
| 14. FATHER'S NAME  |          | 15. MOTHER'S MAIDEN NAME   |                   |  |                                      |  |  |          |
| John F. Mihm   |          | Barbara Near   |                   |  |                                      |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |          | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT ADDRESS  |                                      |  |  |          |
| No   |          | 218-18-7575  |                   | George H. Mihm 1026 Elmridge Road, 21229   |                                      |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |          |  |                   |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I. DEATH WAS CAUSED BY:   |          |  |                   |  |                                      |  |  |          |
| IMMEDIATE CAUSE (a) Acute Massive Myocardial Infarction  |          |  |                   |  |                                      |  | 15 min.                                      |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pseudo.   |          |  |                   |  |                                      |  | 15 yr.                                       |          |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |          |  |                   |  |                                      |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |          |  |                   |  |                                      |  |  |          |
| Diabetes Mellitus  |          |  |                   |  |                                      |  |  |          |
| 19a. DATE OF OPERATION   |          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |          |
|  |          |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |          | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |  |          |
|  |          | HOUR A.M. MONTH DAY YEAR   |                   |  |                                      |  |  |          |
|  |          | P.M. 19  |                   |  |                                      |  |  |          |
| 21d. INJURY OCCURRED   |          | 21e. PLACE OF INJURY   |                   | 21f. LOCATION  |                                      |  |  |          |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |          | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   | STREET   |                                      | CITY OR TOWN COUNTY STATE                                      |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1976, to 3/18/81, 1981, that (I) (we) lost the deceased alive on 3/18/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |          |  |                   |  |                                      |  |  |          |
| 22b. SIGNATURE   |          | DEGREE   |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |                                      | 22c. DATE SIGNED   |  |          |
| I. EARL PASS M.D.  |          |  |                   |  |                                      | 3/19/81  |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |          | 22e. ADDRESS   |                   |  |                                      |  |  |          |
| I. EARL PASS M.D.  |          | 4001 Wilkens Ave   |                   |  |                                      |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |          | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                                      | 23d. LOCATION  |  |          |
| Burial   |          | 03-23-81   |                   | Loudon Park  |                                      | Baltimore City Maryland  |  |          |
| 24. FUNERAL DIRECTOR   |          | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |                                      |  |  |          |
| NAME   |          | 21229  |                   | MAR 20 1981  |                                      |  |  |          |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |          |  |                   |  |                                      |  |  |          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |   |  |   |   |   |  |   | REG. NO. 07092  |   |  |
|--|--|------------------|---|--|---|---|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |                  |   |  |   |   |   |  |   |   |   |  |
| 1a. DECEASED NAME (TYPE OR PRINT)<br>Elijah Huntley  |  |                  |   |  |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3 19 81  |   |  | 2b. HOUR<br>M<br>10:29 P M                                  |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 5 05                           |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>76 YRS.   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 19 81          |   | 24. HOUR<br>P M   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD. |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>313 N. Mount Street |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br>MD   |  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                          |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>313 N. Mount St.                     |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jawah Huntley  |  |                  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma   |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>237-01-6062 |   | 17. INFORMANT<br>ADDRESS<br>Rt. 3 Box 393<br>Rosalee Ragin Manning, S.C.  |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                         |  |                  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                  |   |  |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |   |  |   |   |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |  |                  |   | TITLE (SPECIFY)<br>Assistant M.D.                                      |   |   |   | MEDICAL EXAMINER<br>DATE SIGNED 3/20/81                        |   |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |                  |   | ADDRESS<br>111 Penn St. Balto., MD.                                    |   |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  | 23b. DATE<br>3/27/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk. |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |                  |   |  |   | ADDRESS<br>1101 E. North Ave.   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1981                |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |

1901





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

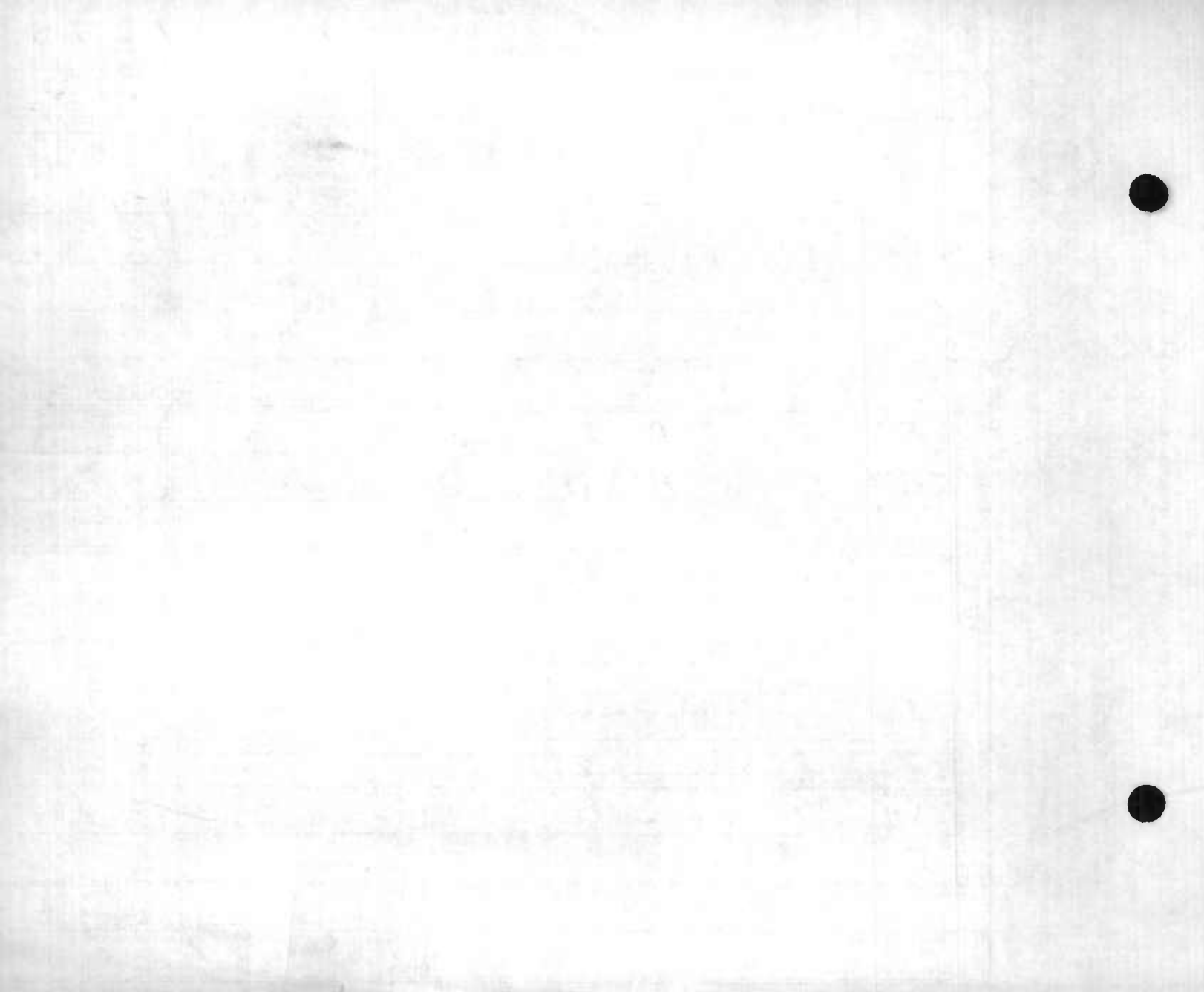
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 3 23 81   |  | 10 55 PM  |  |
| Lucille C. Hutchinson  |  |  |  |   |  |   |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |
| Female   |  | black  |  | MONTH DAY YEAR  |  | 73 YRS  |  |
| 2 16 08  |  |  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |
| N.Y.   |  | U.S.A.   |  |   |  | Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | Providence Hospital  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| 13a. STATE   |  | MD   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | No  |  | 217-16-4068   |  |
| James Lowe   |  |  |  | 17 INFORMANT  |  | ADDRESS   |  |
|  |  |  |  | Helen E. Holland  |  | 2518 McCulloh St.   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 18a. IMMEDIATE CAUSE (a)   |  | 18b. DUE TO, OR AS A CONSEQUENCE OF   |  | 18c. DUE TO, OR AS A CONSEQUENCE OF                                 |  |
| 4140 Renal Failure   |  |  |  | ACVD, B-ventricular failure   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                 |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
| Atherosclerotic Heart Disease  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 3-23 to 19 81, that (I) (we) lost  |  | 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| saw the deceased alive on 3-23 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                |  | Fred C. Thomas M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 3-23 81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  |
| F  |  |  |  | Burial  |  | 3/26/81   |  |
| 24. FUNERAL DIRECTOR   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. COUNTY   |  |
| NAME ADDRESS   |  | Westview Mem. Pk   |  | Baltimore   |  | MD  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  | 23f. DATE REC'D BY REGISTRAR   |  | 23g. REGISTRAR'S SIGNATURE  |  |   |  |
|  |  | MAR 26 1981  |  |   |  |   |  |



RELEASED AS NON MED BY DR GUARD OF THE  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending MEDICAL EXAMINER'S OFFICE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |  |
| 2. DECEASED NAME FIRST MIDDLE LAST<br><b>PAULETTE R. HYMAN</b>   |  |   |  |  |  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 20 59</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>21</b> YRS.   |  | 7. DATE OF DEATH MONTH DAY YEAR<br><b>3 14 81</b> 250 A M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>929 E. 41st. St.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John H. Hyman</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Irma P. Robinson</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>John Hyman 929 E. 41st. Street</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatitis B</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intravenous drug abuse</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> , 19 <b>81</b> , to <b>3/14</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.    |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>C. Francomano</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3/14/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLAIR A. FRANCOMANO MD.</b>  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSP. BALTIMORE 21205</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/20/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial pk</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co MD</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE OF DEATH<br><b>MAR 17 1981</b>  |  |  |  |

MEDICAL CERTIFICATION

*[Handwritten signature]*

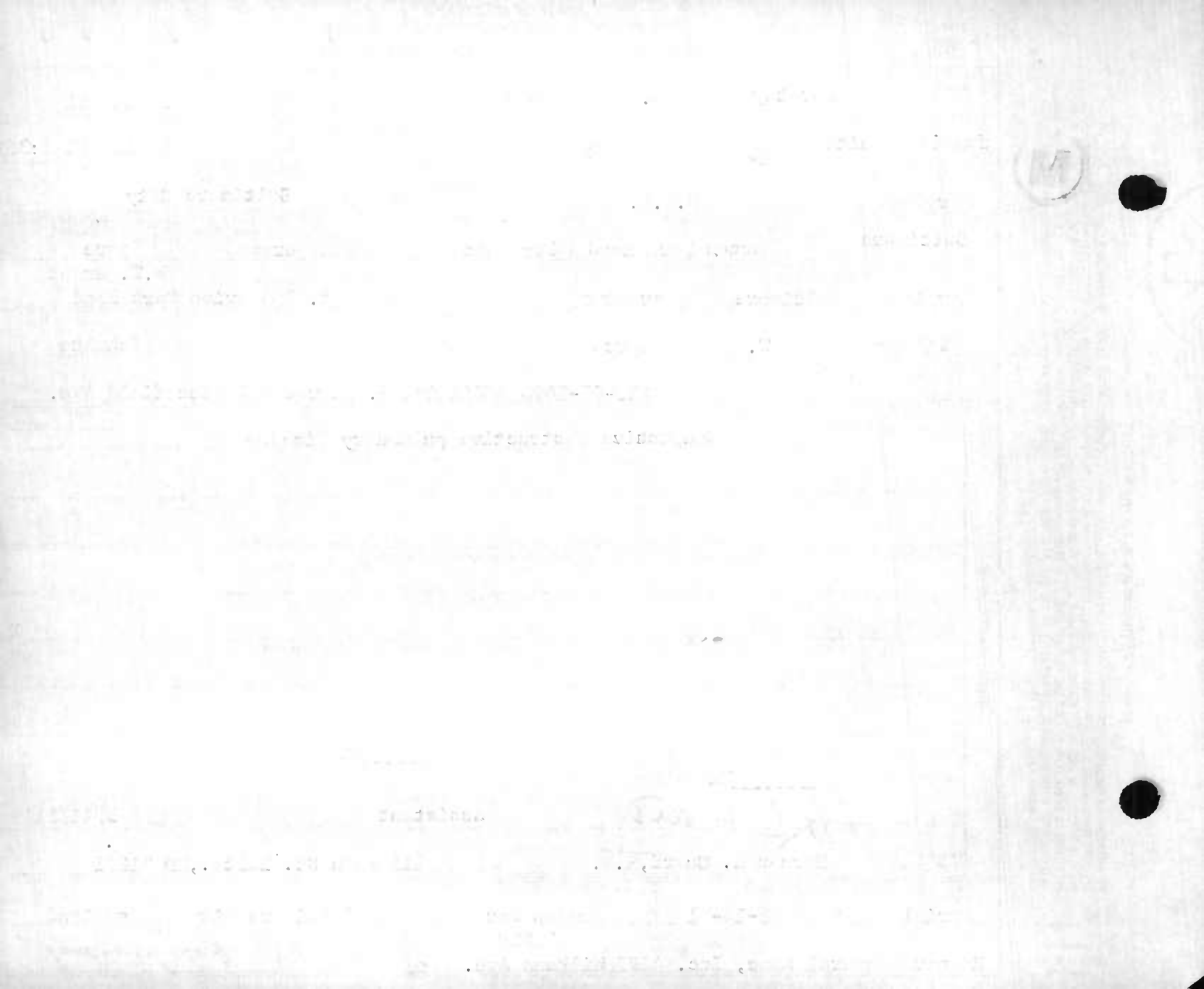
1881  
MAR 1 1881

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |   |   |   |  | REG. NO. 07095   |  |
|--|-------------------------|--|---|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothy E. Ingram</b>   |                         |  |   |   |   |   |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>3 11 81</b> |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>06 24 07</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>73</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3 11 81</b>                                       | 7d. HOUR <b>1:35</b>  |   |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>     |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Apt. 104 Arion Park Road</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesperson</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Store</b> |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>W.T. Grant Apt. 104 Arion Park Road</b> |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbur T. Pearce</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Schulte</b>  |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-07-1498</b>   |   | 17. INFORMANT ADDRESS<br><b>William H. Pearce 627 Beechfield Ave.</b>   |   |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b><br>4960<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                          |                         |  |   |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |   |   |  |  |  |
| ACTUAL SIGNATURE <i>H.R. Guard</i>   |                         |  |   | TITLE (SPECIFY)<br><b>Assistant</b>   |   |   |   | MEDICAL EXAMINER<br>DATE SIGNED <b>3/11/81</b>                                      |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |                         |  |   | ADDRESS <b>111 Penn St. Balto., MD 21201</b>  |   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>03-14-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1981</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Patricia M. Hardy</i>            |   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |                          |   |                                       |  |     | 8 1 0 7 0 9 6   |      |                     |          |  |
|---|--|---|--|---|--------------------------|---|---------------------------------------|--|-----|---|------|---------------------|----------|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |                          |   |                                       |  |     |   |      |                     |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH        |   | MONTH                                 |  | DAY |   | YEAR |                     | 2b. HOUR |  |
| Henry P. IRR  |  |   |  |   | 3 16 81                  |   | 4 45                                  |  |     |   |      |                     | P.M.     |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)   |                                       | IF UNDER 1 YEAR  |     | IF UNDER 24 HRS.  |      |                     |          |  |
| m   |  | CAUC.   |  | MONTH DAY YEAR<br>12 20 98  |                          | 82 YRS.   |                                       | MONTHS DAYS  |     | HOURS MIN.  |      |                     |          |  |
| 7a. BIRTHPLACE (COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |                                       |  |     |   |      |                     |          |  |
| New York  |  | U.S.A.  |  |   |                          |   |                                       |  |     |   |      |                     |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |                                       | 12b. KIND OF BUSINESS OR INDUSTRY                        |     |   |      |                     |          |  |
| Baltimore   |  | Mercy Hospital  |  |   |                          | Ret Ch of Board   |                                       | Banking  |     |   |      |                     |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |                          |   |                                       |  |     | 13d. INSIDE CITY LIMITS?  |      | 13e. STREET ADDRESS |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |                                       | 204 Churchwardens Rd                                     |     |   |      |                     |          |  |
| Maryland  |  | -----   |  | Baltimore   |                          |   |                                       |  |     |   |      |                     |          |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME |   |                                       |  |     |   |      |                     |          |  |
| Desire' Andre' Irr  |  |   |  |   | Mary A. Pittman          |   |                                       |  |     |   |      |                     |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS                 |  |     |   |      |                     |          |  |
| Yes W.W.I   |  |   |  |   | 216 14 3446              |   | Katherine A. Irr 204 Churchwardens Rd |  |     |   |      |                     |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD + CHF</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |                          |   |                                       |  |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |      |                     |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                          |   |                                       |  |     |   |      |                     |          |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   |                                       | 20a. AUTOPSY?  |     | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? |      |                     |          |  |
|   |  |   |  |   |                          |   |                                       | YES <input type="checkbox"/> NO <input type="checkbox"/> |     | YES <input type="checkbox"/> NO <input type="checkbox"/>        |      |                     |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                       |  |     |   |      |                     |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                       |  |     |   |      |                     |          |  |
|   |  |   |  |   |                          |   |                                       |  |     |   |      |                     |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-23-81</u> , 19 <u>81</u> , to <u>3-16-81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-16</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                          |   |                                       |  |     |   |      |                     |          |  |
| 22b. SIGNATURE<br><u>Peter T. Lapinsky MD</u>   |  |   |  |   |                          | DEGREE  |                                       | 22c. DATE SIGNED<br><u>3-16-81</u>                       |     |   |      |                     |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PETER T. LAPINSKY</u>   |  |   |  |   |                          | 22e. ADDRESS<br><u>MERCY HOSP. BALTO MD</u>                                   |                                       |  |     |   |      |                     |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |     |   |      |                     |          |  |
| Burial  |  |   |  | 3-19-81   |                          | Lorraine Mausoleum  |                                       | Baltimore ----- Maryland                                 |     |   |      |                     |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Mitchell-Wiedefeld Home</u>  |  |   |  |   |                          | ADDRESS<br><u>6500 York Rd 21212</u>  |                                       | 25a. DATE RECD. BY REGISTRAR<br><u>MAR 20 1981</u>       |     | 25b. REGISTRAR'S SIGNATURE<br><u>Peter T. Lapinsky</u>          |      |                     |          |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 0 9 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                             |  |   |  |
|--|--|--|---|---|-----------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES RICHARD ISRAIL                |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 20, 1981           |   |                             | 2b. HOUR<br>6:30 P.M.  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 7, 1965   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>15 YRS.                               |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DEATON MEDICAL CENTER |   |   |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>NONE |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A                                   |  |  |   |   |                             |  |   |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Anne Arundel                                     |   | 13c. CITY OR TOWN<br>Severn |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>747 Elmhurst Road                                   |  |  |   |   |                             |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack R. Israil                   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Wanda F. Keith |   |                             |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>N/A  |   | 17. INFORMANT<br>Same as 13 (Grandmother)<br>Mrs. Ella Mae Arbogast   |                             |  |   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia - aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9298</u><br>(b) <u>Severe Brain damage - Comatose</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Near Drowning</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 hrs.</u><br><u>30 mos</u><br><u>8-15-78</u> |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Max Fan's Syndrome

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><u>9-7-79</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Near drowning while fishing</u> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 8 15 1979                      |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>Near drowning while fishing</u> |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK<br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>POND</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>611 S Charles Street Balto Md 21250</u>                         |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>3-20-81</u> to <u>3-20-81</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-20-81</u> , and that (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>LOS ZERBLEY MD</u>   |  | DEGREE<br><u>Physician</u>   |  |   |  | 22c. DATE SIGNED<br><u>3-20-81</u>  |  |
| 22d. PHYSICIAN'S NAME (THIS CERTIFICATE)  |  | 22e. ADDRESS<br><u>611 S Charles Street Balto Md 21250</u>                             |  |   |  |   |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial             |  | 23b. DATE<br>March 24, 1981 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem.Pk. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Singleton Funeral Home Md. |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1981             |  | 25b. REGISTRAR'S SIGNATURE<br><u>Raymond H. Brady</u>               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

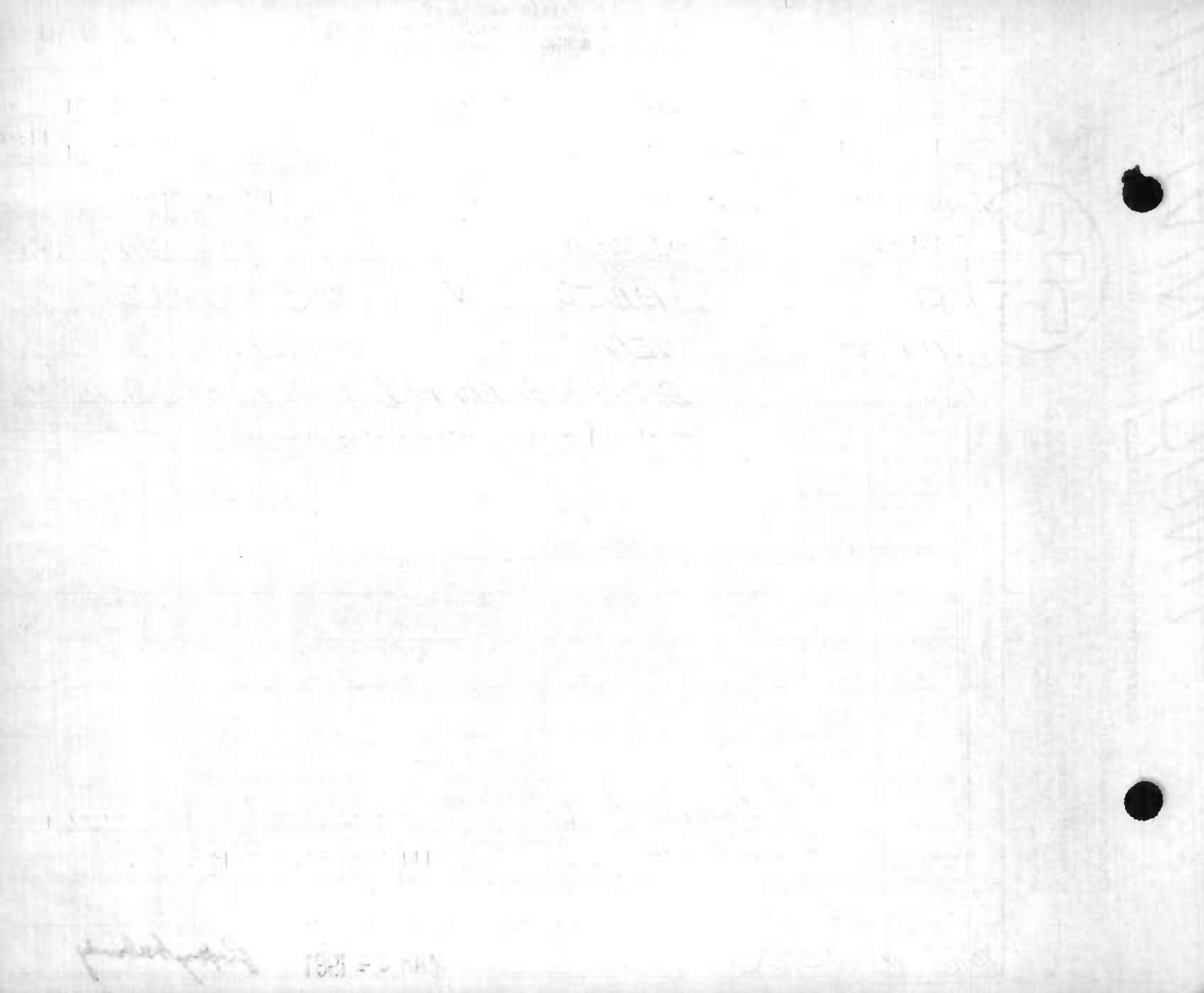
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |   |  |  |  | REG. NO. 07098   |  |
|--|--|---------------|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) Anna M. Jackson   |  |               |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 21 81 |  |
| 3. SEX Female  |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 4-4-1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.                                       |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 2b. HOUR M 11:40 a M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.                                       |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2043 Gough Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) APP STORES   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE MD  |  |               |  | 13b. COUNTY BALTO   |  | 13c. CITY OR TOWN BALTO   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 2043 Gough ST.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS HEAVY   |  |               |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN                            |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO  |  |               |  | 16b. SOCIAL SECURITY NO. 217-14-2321  |  | 17. INFORMANT ADDRESS DONALD COUGHLIN 346 WALTER RD                           |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |               |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |               |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |               |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE Thomas D. Smith   |  |               |  | TITLE (SPECIFY) M.D. Deputy Chief   |  |   |  | DATE SIGNED 3/22/81  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |  |               |  | ADDRESS III Penn St. Balto., MD.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION  |  |               |  | 23b. DATE 3-24-81   |  | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW                                   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME JOHN M. WEBER & SONS INC   |  |               |  | ADDRESS 401 S. CHESTER  |  | 25a. DATE REC'D. BY REGISTRAR MAR 24 1981                                     |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

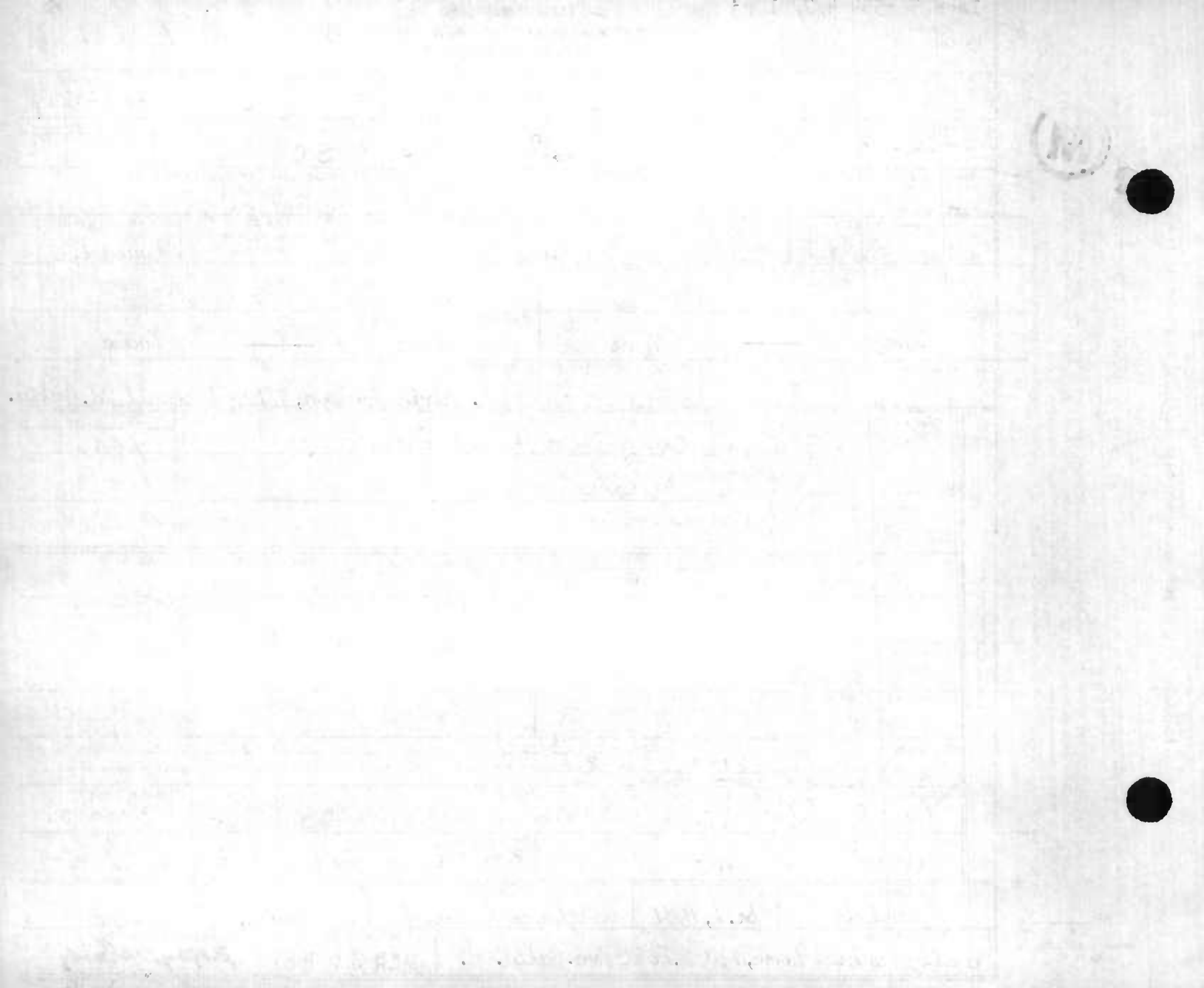
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5 8554 4/7/81 83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8107099

|  |   |   |  |
|--|---|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>DORA NMI JACKSON  |   | MONTH DAY YEAR HOUR<br>3 29 81 3:27 PM  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |
| FEMALE   | white   | MONTH DAY YEAR<br>3 27 1909   | 80 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |
| Maryland   | U.S.A.  |   | Baltimore City MD.   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Baltimore, Maryland  | Bon Secour Hosp.  | Retired   | Housewife  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE   | 13b. COUNTY   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS  |
| Maryland   |   |   | 128 W. Ostend Street   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |
| George ----- Hagen   | Alice ----- Toome   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS   |  |
| No   | 215-244672  | Mr. Melvin Jackson, 3710 Clarendell Rd. Balto.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>yes<br>yes   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>COPD, pneumonia   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/27, 19 81, to 3/27, 19 81, that (I) (we) last saw the deceased alive on 3/27, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |   |  |
| 22b. SIGNATURE<br>Michael Pinsky   | DEGREE<br>MD  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br>3/27/81  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL PINSKY  | 22e. ADDRESS<br>BON SECUR 2000 W Baltimore St   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Apr. 1, 1981   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1981  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 1 0 7 1 0 0  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST<br><i>Ester E. Jackson</i>  |  |  |  | MONTH DAY YEAR HOUR<br><i>3-26-81 7:30 P.M.</i>  |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| <i>Female</i>   |  | <i>Black</i>   |  | MONTH DAY YEAR<br><i>4 12 97</i>   |  | <i>83</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| <i>S.C.</i>   |  | <i>U.S.A.</i>  |  |  |  | <i>Balto. City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| <i>Balto.</i>   |  | <i>Lutheran Hospital</i>   |  | <i>None</i>  |  | <i>None</i>  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| <i>Md.</i>  |  |  |  |  |  | <i>City</i>  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST<br><i>Joseph Harrison</i>   |  |  |  | FIRST MIDDLE LAST<br><i>Katie Harrison</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| <i>NO</i>   |  |  |  |  |  | <i>Bessie Griffin 3605 W. Lexington</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary embolism</i>  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sepsis</i>  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
|   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/1/81</i> to <i>3/26/81</i> , that (I) (we) last saw the deceased alive on <i>3/26/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>K. NAIR</i>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | <i>3-26-81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |  |  |
|   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| <i>Burial</i>   |  | <i>3-30-81</i>   |  | <i>King Mem. PK.</i>   |  | <i>RANDALSTOWN, Md.</i>  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>JAS. A. MORTON &amp; SONS 1701 LAURENS</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |  |  | <i>MAR 30 1981</i>   |  | <i>[Signature]</i>   |  |

U.S.A. 20

Joseph Thompson Katie  
Boris (left) 2022 in training

Jan A. Morrison + 2022 2021 2020  
Mar 20 1981  
But-21 2-20-81 Prince Man. TX  
H-4

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 10  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

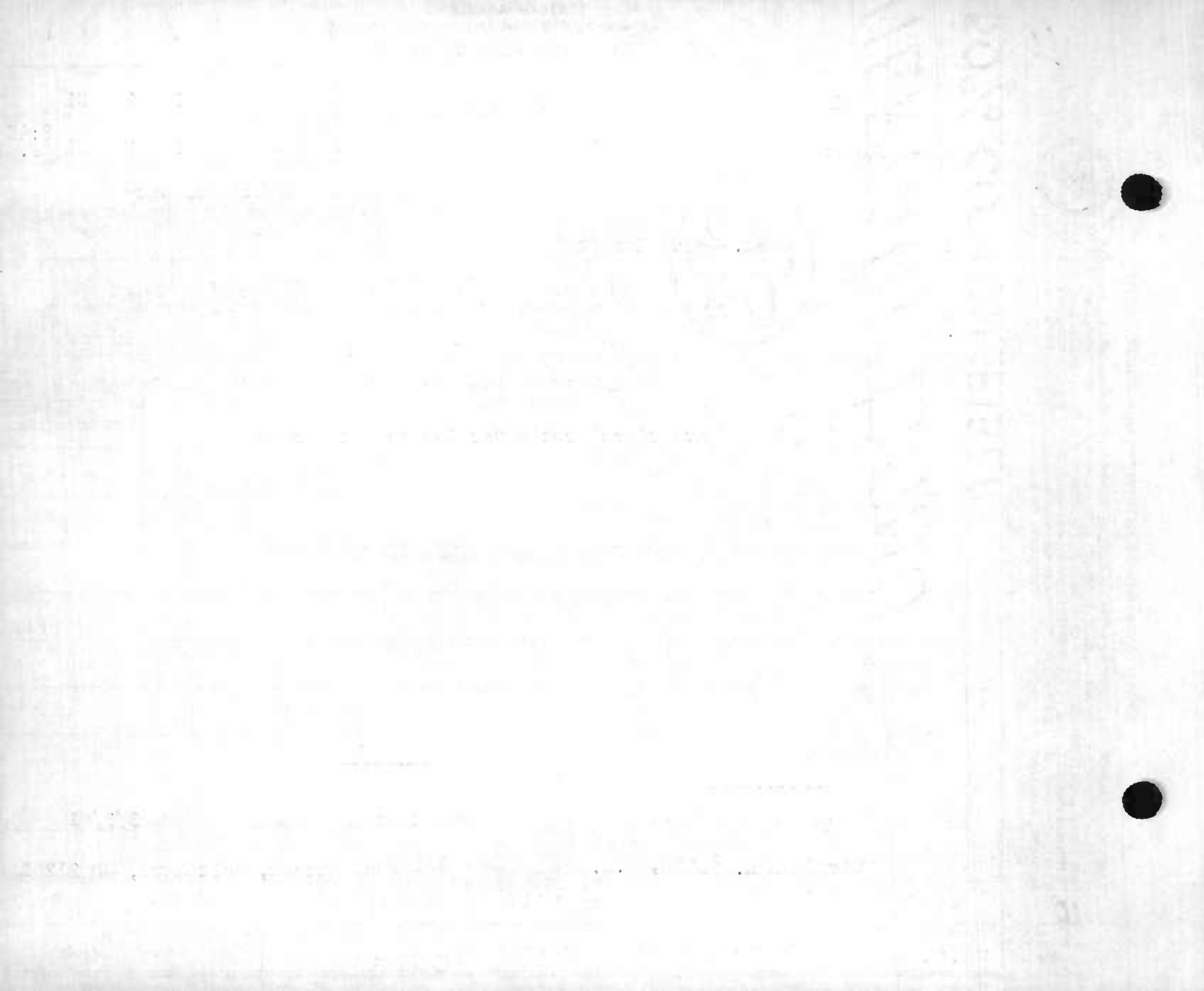
REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|---------------------|--|------------------|--|--------------------------------------|--|-------|--|------|--|---|--|---|--|----------------------------------|--|-------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | KNOWN ESTIMATED  |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR  |  |   |  |                                  |  |                   |  |  |  |  |  |
| LUCILLE  |  |  |  |   |  | JACKSON   |  | 3                   |  | 2                |  | 19                                   |  | 81    |  |      |  | M   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.      |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED                  |  | MONTH |  | DAY  |  | YEAR  |  | 2d. HOUR  |  |                                  |  |                   |  |  |  |  |  |
| Female   |  | Black  |  | 3 3 23  |  | 57 YRS.   |  |                     |  |                  |  | 3                                    |  | 2     |  | 19   |  | 81  |  | 8:45 P.M.   |  |                                  |  |                   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED             |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| S.C.   |  | USA  |  |   |  |   |  |                     |  |                  |  | Baltimore City                       |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| Baltimore  |  | St. Agnes Hospital                                       |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| Maryland   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4400 Manorview Road |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| Will   |  | Ella   |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| No   |  | 242-44-7588  |  | Audrey Flood  |  | 304 N. Denison Street   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |   |  |                                  |  |                   |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| (b)  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| (c)  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  |                                  |  |                   |  |  |  |  |  |
|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                                  |  |                   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                  |  |                   |  |  |  |  |  |
|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | HOUR A.M. MONTH DAY YEAR                                    |  |   |  |                                  |  |                   |  |  |  |  |  |
|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | P.M. 19   |  |   |  |                                  |  |                   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |                                  |  |                   |  |  |  |  |  |
|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |                                  |  |                   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | Autopsy <input type="checkbox"/>                            |  | Inspection <input checked="" type="checkbox"/>                                |  | Inquiry <input type="checkbox"/> |  | and in my opinion |  |  |  |  |  |
| Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  |   |  |   |  |                                  |  |                   |  |  |  |  |  |
| ACTUAL SIGNATURE Virginia L. Dolan   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |                                  |  |                   |  |  |  |  |  |
|  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | M.D. Assistant  |  | MEDICAL EXAMINER  |  | 3/3/81                           |  |                   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | ADDRESS   |  | 111 Penn Street, Baltimore, MD 21201  |  |                                  |  |                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                    |  |                   |  |  |  |  |  |
| Burial   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 3/7/81  |  | Cedar Hill Cemetery   |  | Anne Arundel Co.,                |  | MD.               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |  |                                  |  |                   |  |  |  |  |  |
| WM.C. MARCH F/H INC.   |  |  |  |   |  |   |  |                     |  |                  |  |                                      |  |       |  |      |  | 1101 E. North Ave.  |  | MAR 4 1981  |  |                                  |  |                   |  |  |  |  |  |

07101

2864



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

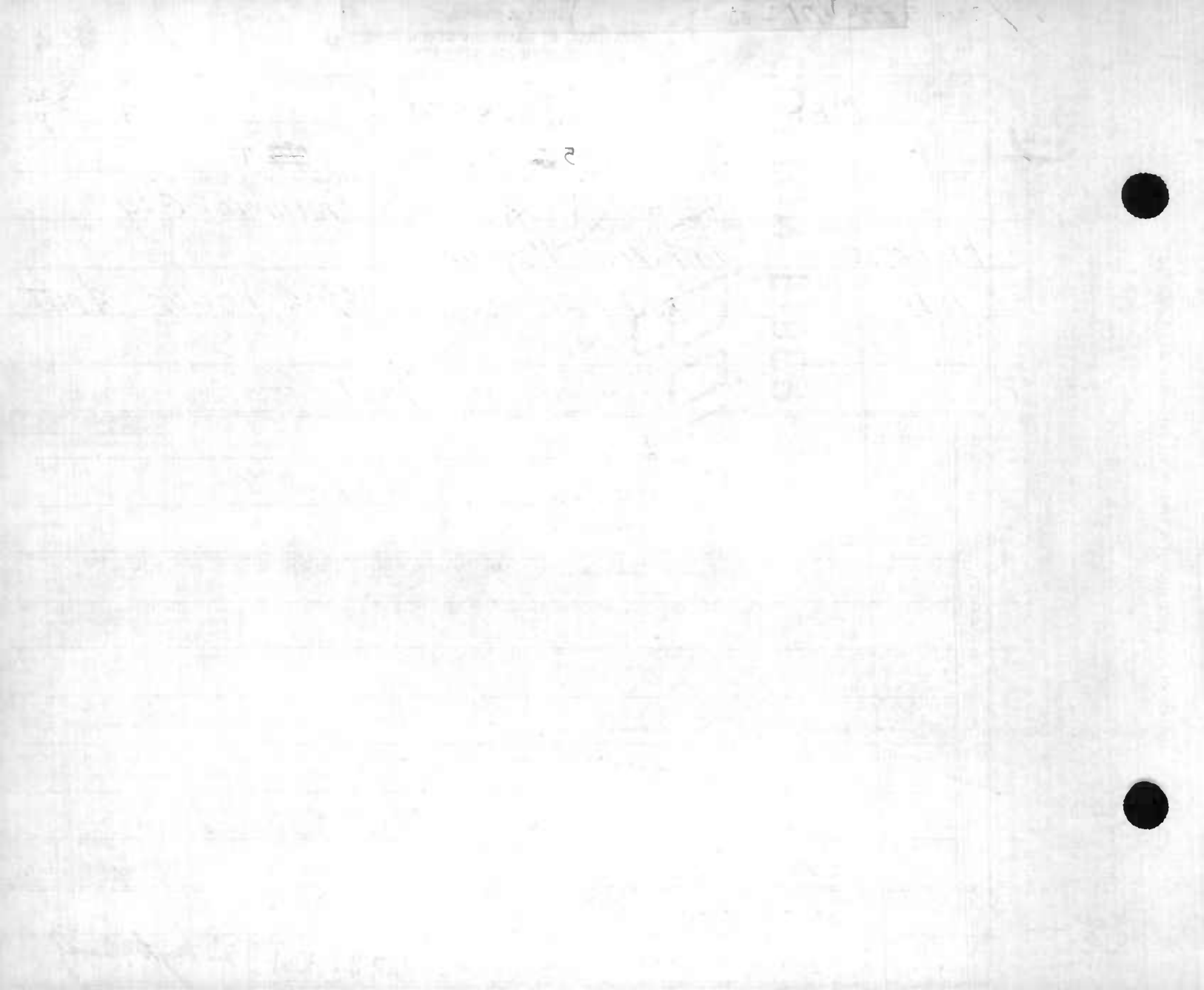
Item 5 8554 4/7/81 gj

FOR  
1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8107102

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST M A E<br>MIDDLE S.<br>LAST JACKSON  |   |   | 2a. DATE OF DEATH<br>MONTH 3<br>DAY 26<br>YEAR 81                          |   | 2b. HOUR<br>2:30 p.m.  |
| 3. SEX<br>F   | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH 5<br>DAY 22<br>YEAR 05  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)              |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3313 Poplar Street  |
| 14. FATHER'S NAME<br>FIRST Rubin<br>MIDDLE<br>LAST Stith  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Sallie<br>MIDDLE<br>LAST Moody  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>223-20-8822   |  | 17. INFORMANT<br>Willie Jackson 5716 Denwood Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>7070<br>DUE TO, OR AS A CONSEQUENCE OF (b) DECUBITUS ULCER<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                 |   |   |  |   |  |
| 22b. SIGNATURE<br>S. Sowanagool   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. SOWANAGOOOL   |   | 22e. ADDRESS<br>LUTHERAN HOSPITAL BALTIMORE, MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>3/31/81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Stith Cem.                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Stoney Creek VA  |
| 24. FUNERAL DIRECTOR<br>NAME Wm. C. March F/H<br>ADDRESS 1101 E. North Ave.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981<br>25b. REGISTRAR'S SIGNATURE |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

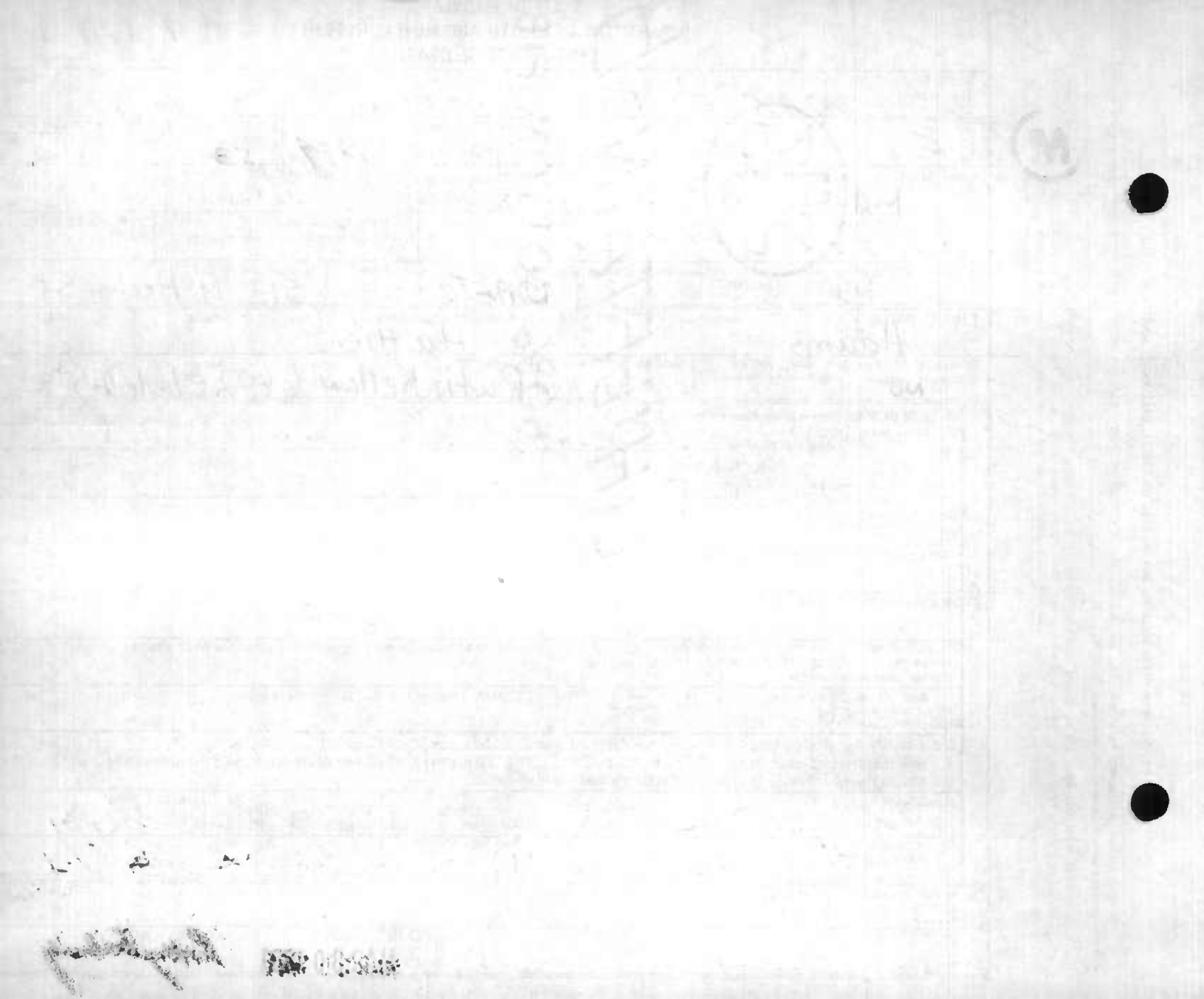
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07103

|   |  |   |  |   |   |  |   |  |   |   |  |
|---|--|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARIE E. JACKSON</b>   |  |   | 20. DATE OF DEATH<br>Month <b>3</b> Day <b>22</b> Year <b>81</b>                               |   |   | 2b. HOUR<br>M  |   |  |   |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>BLACK</b>                       |  | 5. DATE OF BIRTH<br><b>12-31-1897</b>   |   | 6. AGE (In years<br>lost birthday)<br><b>83</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |   | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>City</b>  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>GRANADA</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MD.</b>   |  |   | 13b. COUNTY<br><b>BALTO.</b>   |   | 13c. CITY OR TOWN<br><b>BALTO.</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>513 McMechen St</b>                        |   |  |
| 14. FATHER'S NAME<br>First <b>Adams</b> Middle <b></b> Last <b></b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Hattie</b> Middle <b></b> Last <b></b>                    |   |   |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-34-4096</b>   |   | 17. INFORMANT<br><b>Ruth Kellam</b>                             |  |   | Address<br><b>6622 Eberle Dr Apt 302</b>                             |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EOLARY 1 Km. back</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |  |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                              |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/27/1979</b> , to <b>3/27/81</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/27/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Hollis Pennington, MD</b>  |  |   |  |   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>3/27/81</b>                                      |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>HOLLIS PENNINGTON, MD</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>1010 Park Rd Baltimore Md</b>   |   |  |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/30/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cemetery</b> |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>William C. March F/H 1101 E. North Ave</b>   |  |   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 30 1981</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. [Signature]</b>                  |   |  |



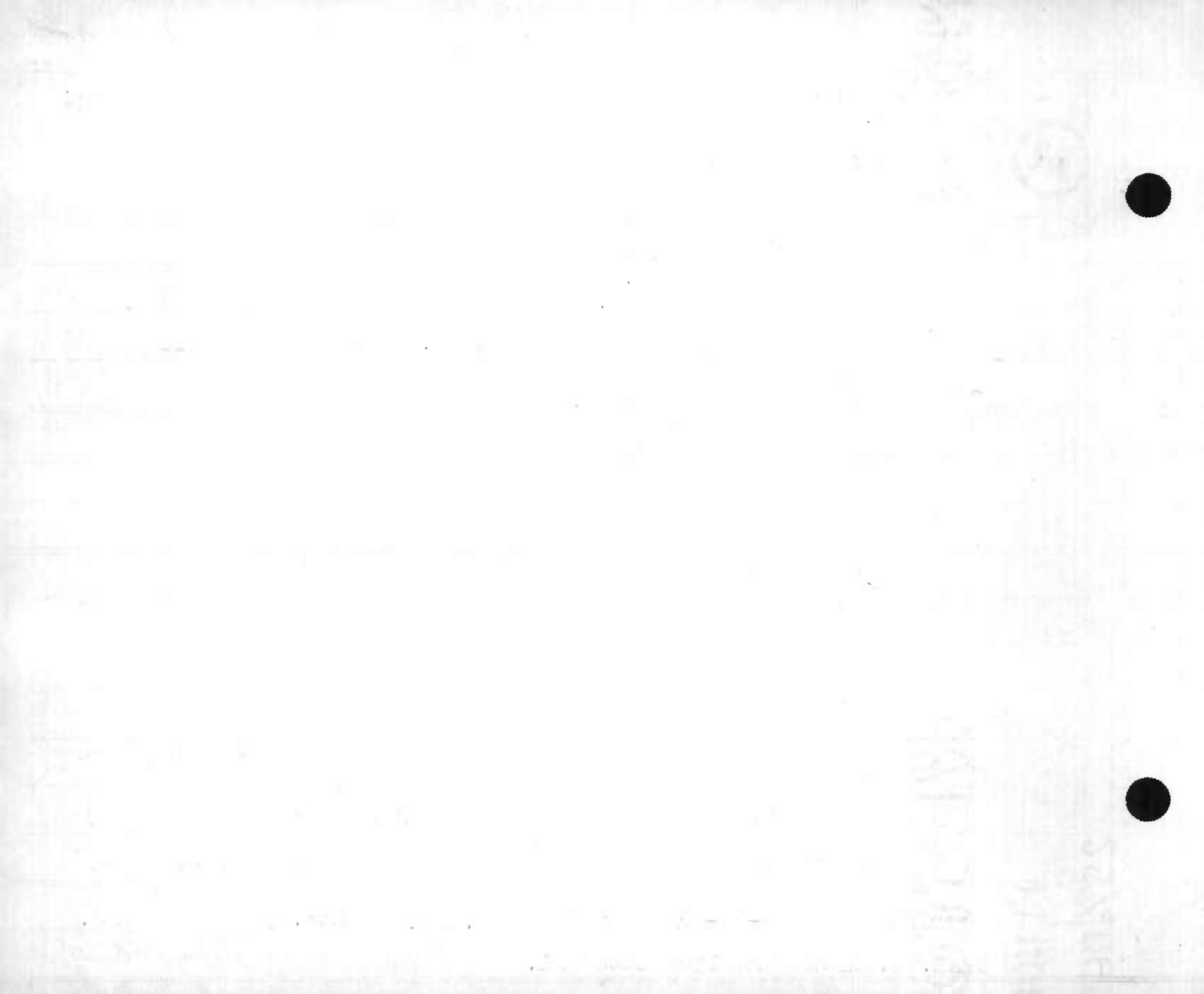


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| FOR<br>STATE<br>REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 0 7 1 0 4  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR   |  |   |  |
| Matilda JACKSON  |  |   |  | 3 19 81  |  |  |  | 7 15 M   |  |   |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |  |
| Female   |  | Black   |  | 2 23 96  |  | 85 YRS.  |  | MONTHS   |  | OAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| Maryland   |  | USA   |  |  |  | Baltimore City   |  |  |  | MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |
| Baltimore  |  | MT Sinai Nursing Home   |  |  |  |  |  |  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13a. CITY OR TOWN  |  |  |  | 13b. INSIDE CITY LIMITS?                                 |  |   |  |
| 13a STATE  |  |   |  | 13b COUNTY   |  |  |  | 13c. STREET ADDRESS                                      |  |   |  |
| md   |  |   |  | Baltimore  |  |  |  | 2414 W. Lexington ST                                     |  |   |  |
| 14 FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |
| FIRST MIDDLE LAST  |  |   |  | FIRST MIDDLE LAST  |  |  |  |  |  |   |  |
|  |  |   |  | Maggie   |  |  |  | Foot   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO   |  |  |  | 17 INFORMANT ADDRESS                                     |  |   |  |
| No   |  |   |  | 215-03-5077  |  |  |  | MT. SINAI N. H. 4613 PK. Heights Ave 2/2/81              |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY  |  |   |  |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a)  |  |   |  |  |  |  |  |  |  |   |  |
| PNEUMONIA  |  |   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |  |  |   |  |
| (b)  |  |   |  |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |  |  |   |  |
| (c)  |  |   |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |   |  |
| DM CRF   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
|  |  |   |  | P.M. 19  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-28 19 79, to 3-19-81, that (we) lost<br>saw the deceased alive on 3-19 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (I do) (I do not) (we do) (we do not) view the body after death. |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |   |  |
| D. WETSON  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 3-21-81  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| D. WETSON  |  |   |  | 3640 FORDS LANE BALTO 21245  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |  |   |  |
| Burial   |  |   |  | 3-26-81  |  | Arbutus Mem. Pk.   |  | Balto. Md.   |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                               |  |   |  |
| CHAS. A. RICE FSPA 1300 Eutaw Pl.  |  |   |  |  |  | MAR 26 1981  |  | [Signature]  |  |   |  |

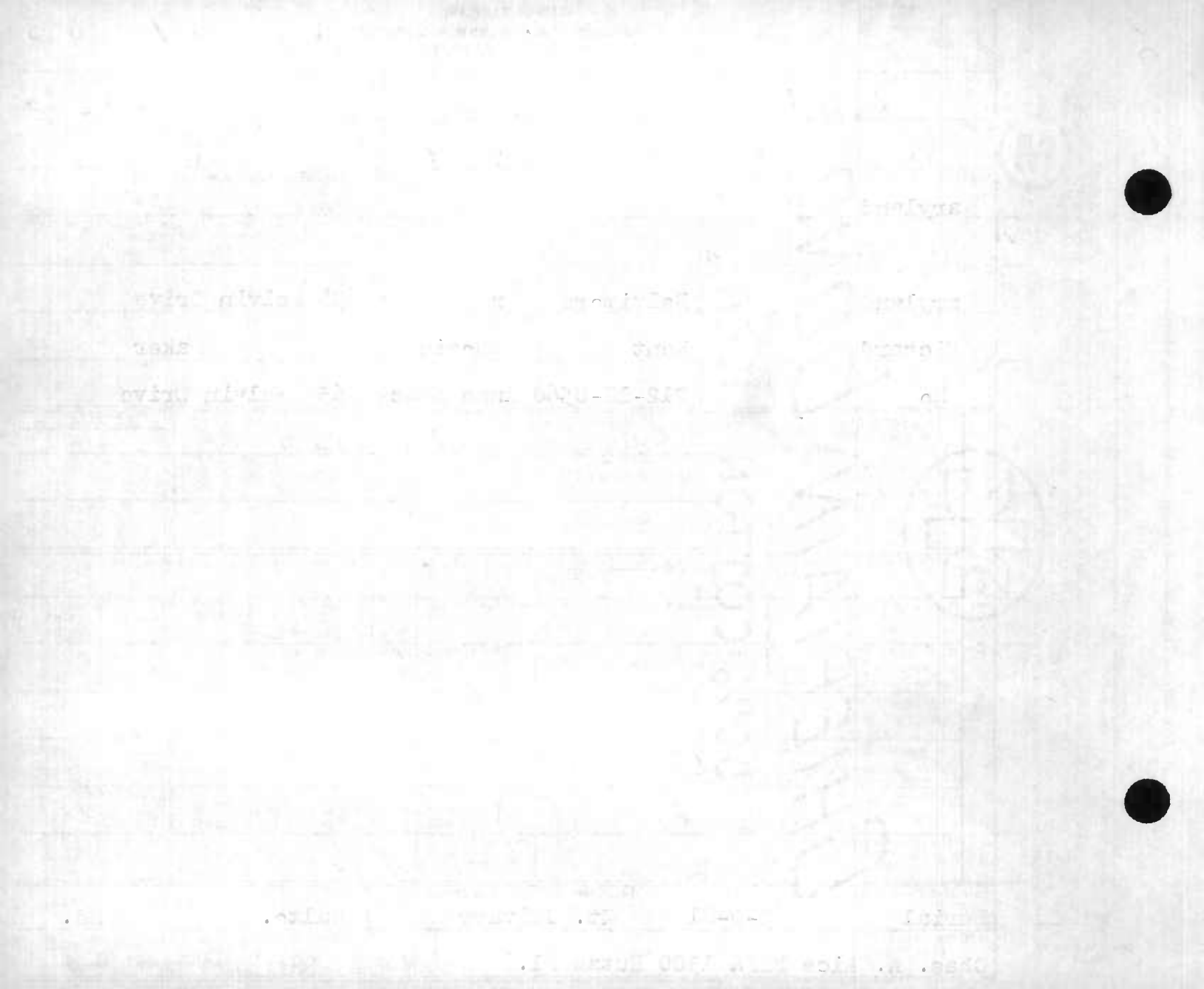


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8107105  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Richard Jackson</i>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 3 81</i>   |  | 2b. HOUR<br><i>2:50 PM</i>   |   |
| 3. SEX<br><i>M</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 7 00</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>80</i>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO CITY</i> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MERCY HOSP.</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><i>654 Melvin Drive</i>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Richard Kent</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Rosie Maker</i>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>212-18-0560</i>   |  | 17. INFORMANT ADDRESS<br><i>Anna Black 654 Melvin Drive</i>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>PANCREATIC CARCINOMA</i><br><i>1579</i><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mos.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/79</i> to <i>3/3/81</i> , that (I) (we) last saw the deceased alive on <i>3/3/81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br><i>J. Snyder</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  | 22c. DATE SIGNED<br><i>3/3/81</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SNYDER</i>  |  |  |  | 22e. ADDRESS<br><i>MERCY HOSPITAL</i>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>3-6-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Chas. A. Rice FSPA 1300 Eutaw Pl.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 5 1981</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Rader</i>   |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 1 0 6

1- FOR  
STATE  
REGISTRAR *2*

REG. NO.

|  |   |  |   |  |   |
|--|---|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Sammy</b><br>( <b>Samuel</b> ) <b>Lee Jackson</b> |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 6, 1981</b>  |  | 2b. HOUR<br><b>5:34P</b> M                              |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 18 29</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS.                 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA Medical Center, Perry Point, Md</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2612 Llewellyn Avenue</b>              |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Willie Jackson</b>                             |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sallie Jones</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>          | 16b. SOCIAL SECURITY NO.<br><b>215 24 7494</b>  | 17. INFORMANT ADDRESS<br><b>Sallie Manning 1503 Dallas Street</b>  |   |  |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**Huntingtons Chorea**

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December 17, 1979</b> to <b>March 6, 1981</b> .                                    |  |  |  |
| 22b. SIGNATURE<br><i>Kam Ken Leung</i>   |  | 22c. DATE SIGNED<br><b>3-6-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kam-Ken Leung</b>  |  | 22e. ADDRESS<br><b>VAMC, Perry Point, Md</b>   |  |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                    | 23b. DATE<br><b>3/11/81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery Baltimore</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. March, Baltimore, Md.</b> |                             | 25a. DATE RECD. BY REGISTRAR<br><b>MAR 9 1981</b>                         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>ANNA L JACOBS  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/5/81  |  | 2b. HOUR<br>10 <sup>00</sup> PM   |  |
| 3. SEX<br>F   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 27 18   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br># UNDER 1 YEAR<br># UNDER 24 HRS<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ind.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. STREET ADDRESS<br>4911 Goodnow Road Apt. B   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Hampton   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Naomi  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Paul D. Jacobs 4911 Goodnow Rd. APt B   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pulmonary edema</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myocardial infarction</u>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr 15 min</u><br><u>1 day</u><br><u>unknown</u>                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 5</u> , 19 <u>81</u> , to <u>March 5</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>March 5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>So, MD  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/5/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>So   |  |  |  | 22e. ADDRESS<br>22 S. Greene St. Balto, MD. 21201   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/10/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MD. NAT. MEM. PK.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. C. MARCH F/H INC. 1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br>MAD 9 1981 [Signature]   |  |   |  |

SECRET

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(M)

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SECRET

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SECRET

PICU7

2 1940998

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician, and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 0 7 1 0 8

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Chad Michael Jacobs</b><br>(Chad M. Jacobs)  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>03/26/81</b>   |  | 2b. HOUR<br><b>6:25p</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 21 1980</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS <b>5</b> MONTHS <b>5</b> DAYS <b>5</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Usa</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Hawthorne</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Kenneth J. Jacobs</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Sandra Breeden</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b>   |  | 17. INFORMANT ADDRESS<br><b>Kenneth J. Breeden 2133 Redthorn Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROFOUND CEREBRAL DYSFUNCTION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b><br>7452 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIAC ARREST</b> <b>3 WEEKS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGENITAL HEART DISEASE</b> <b>SINCE BIRTH</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>RENAL FAILURE, HEMATIC FAILURE</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/4/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>TETRALOGY OF FAULT</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/11/81</b> , 19____, to <b>3/26/81</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/26/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sally J. Jones</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/26/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SALLY JONES</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/28/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Overlea Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Lassan F H</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 1 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 1 0 9

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH J. JAKUBOWSKI</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 22, 1981</b>                                    |  | 2b. HOUR<br><b>5:15 A.M.</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 18, 1908</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE MARYLAND City MD.</b>           |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>130 S. WASHINGTON ST.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LONGSHOREMAN</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MD. PORT AUTH.</b>                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>-----</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>130 S. WASHINGTON STREET</b>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN JAKUBOWSKI</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA PRAJS</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW 2</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-09-3448</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>CHARLES WINIARSKI 940 ROSEDALE AVE 21237</b>          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5715</b> IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)                            |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>m7</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-18-80</b> , 19 <b>80</b> , to <b>6-22-81</b> , 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>6-23-</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>M.T. M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>Mar 24, 1981</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MOHAMMAD TAQI M.D.</b>  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL INC.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>MAR 25, 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEM</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>HOWARD CO., MD.</b>                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc.</b>   |   | ADDRESS<br><b>7110 Belair Road<br/>Baltimore, Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1981</b>                                  |  |

Funeral Home, Inc. 1234 12th St. N.W.

Church of the Holy Spirit, N.W.

1234 12th St. N.W.

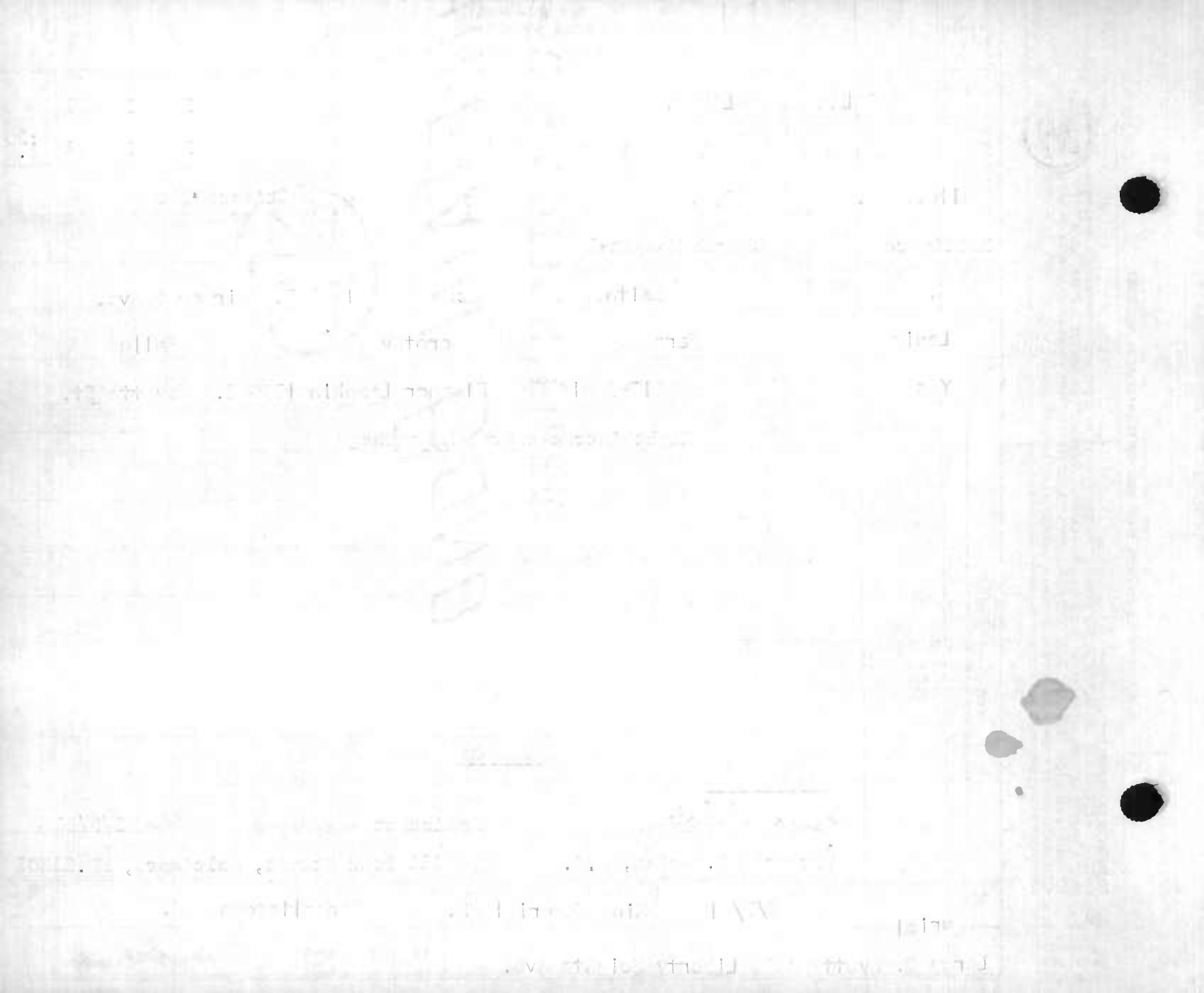
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |  | REG. NO. 07110  |  |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CAROL LAURETTA JAMES</b>  |  |                      |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 3 19 81</b> |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 28 42</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>38 YRS.</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7c. DATE PRONOUNCED DEAD <b>3 3 19 81</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                                  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                      |  |   |  |  |  |  |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY          |  | 13c. CITY OR TOWN <b>Balto.,</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1907 E. Fairmount Ave.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Louis Farabee</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Dorothy Fallee</b>                          |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>217-38-1406</b>   |  | 17. INFORMANT ADDRESS <b>Eleanor Lampkin 1730 E. Fayette St.</b>                             |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Right intracerebral hemorrhage</b><br>4310<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                      |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                      |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b>   |  |  |  | DATE SIGNED <b>3/3/81</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street, Baltimore, MD. 21201</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>3/7/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Randallstown, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Leroy O. Dyett 4600 Liberty Heights Ave.</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 5 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |  |   |  |  |
|---|--|---|--|---|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Evelyn M. James</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 30 81</b><br>7b. HOUR<br><b>6:30 PM</b> |  |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 31 1914</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |  |   |  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><b>2520 Yorkway</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mack McBrian</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie Isenock</b>               |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-07-0420</b>   |  | 17. INFORMANT<br><b>Jesse R. James</b>  |   | ADDRESS<br><b>2526 McComas Ave. Balto., MD. 21222</b>                                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4275</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Robert T. Schreiber</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  |   | 22c. DATE SIGNED<br><b>3/30/81</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert T. Schreiber</b>   |  |   |  |   | 22e. ADDRESS<br><b>Baltimore City Hospital, Balto MD 21224</b>                      |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/3/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 2 1981</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |  |



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 1 0 7 1 1 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Melvin James, Sr. |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 9, 1981                                 |   | 2b. HOUR<br>1250 <sup>PM</sup>            |
| 1. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 22, 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   | 12a. USUAL OCCUPATION (Ret.)<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Draftsman | 12b. KIND OF BUSINESS OR INDUSTRY<br>West-inghouse  |   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Hanover   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>19 Leeds Road      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles E. James                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nora Ellen Reynolds  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES           |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. II  | 17. INFORMANT (Wife)<br>ADDRESS<br>Mrs. Priscilla I. James Same as # 13              |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart failure

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) intraoperative myocardial infarct

DUE TO, OR AS A CONSEQUENCE OF

(c) Coronary artery disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |   |   |  |  |
|--|---|---|--|--|
| 19a. DATE OF OPERATION<br>3/9/81   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Coronary artery disease |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/9, 1981, to 3/9, 1981, that (I) (we) last saw the deceased alive on 3/9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |
| 22b. SIGNATURE<br>Albert M. Lai, M.D.  | DEGREE  |   | 22c. DATE SIGNED<br>3/9/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Albert M. Lai, M.D.   | 22e. ADDRESS<br>22 S. Greene Street   |   |  |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation | 23b. DATE<br>March 12, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto., Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home    |                             | 25a. DATE REC'D. BY REGISTRAR<br>MAR 12 1981           |   |
| ADDRESS<br>Glen Burnie Md.                                |                             | 25b. REGISTRAR'S SIGNATURE<br>[Signature]              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MAR 12 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 1 0 7 1 1 3

## CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE LAST JARCEWSKI  |  |   | 2a. DATE OF DEATH<br>MONTH 03 DAY 27 YEAR 81  |  | 2b. HOUR<br>3:32pm   |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH 11 DAY 30 YEAR 1921   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>FOOD SERVICE MGR. BALTO CITY |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. STATE<br>MARYLAND   | 13b. COUNTY  | 13c. CITY OR TOWN<br>BALTIMORE  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3604 ROBERTS PLACE                                      |  |
| 14. FATHER'S NAME<br>FIRST ANDREW MIDDLE URBANOWSKI LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST STELLA MIDDLE FRANKOWSKI LAST   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>219 05 8886   |   | 17. INFORMANT<br>ADDRESS<br>EDWARD JARCEWSKI 3604 ROBERTS PL.                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA LUNG WITH METASTASIS<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                        |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) this hospital attended the deceased from 03-16-1981 to 03-27-1981, that (I) we last saw the deceased alive on 03-27-1981, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br>A. F. Nazemi M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br>3/27/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. A. F. NAZEMI M.D.   |  | 22e. ADDRESS CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY BALTIMORE, MARYLAND 21231   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |
| BURIAL   | 3/31/1981  | Holy Rosary Cem   |   | BALTIMORE MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| RAYMOND L. KACZOROWSKI   |  | APR 7 1981  |   | [Signature]  |  |



APR 1 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 0 7 1 1 4

|   |  |   |   |  |   |  |  |
|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALONZO M. JARRETT  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 / 3 / 81                                   |  |   | 2b. HOUR<br>12:10 PM   |  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>September 6, 1901   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                          |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Foreman |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>4600 Seifert Ave  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Jarrett  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>? ? ?                              |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-01-2806  |   | 17. INFORMANT<br>ADDRESS<br>Mrs Joan E Ballman 5017 Anntana Ave  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest.</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/81</u> , 19____, to <u>3/3/81</u> , 19____, that <del>the</del> (we) lost saw the deceased alive on <u>3/3/81</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (do not) view the body after death.              |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>C. J. Huddleston M.D.</u>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3/3/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. J. HUDDLESTON   |  |   |   | 22e. ADDRESS<br>Union Mem. Hosp.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/7/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Landon Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J Ruck Inc. Baltimore, Maryland   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1981  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McBratney</u>  |  |

2641

100% COTTON FIBER

UNWASHED COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

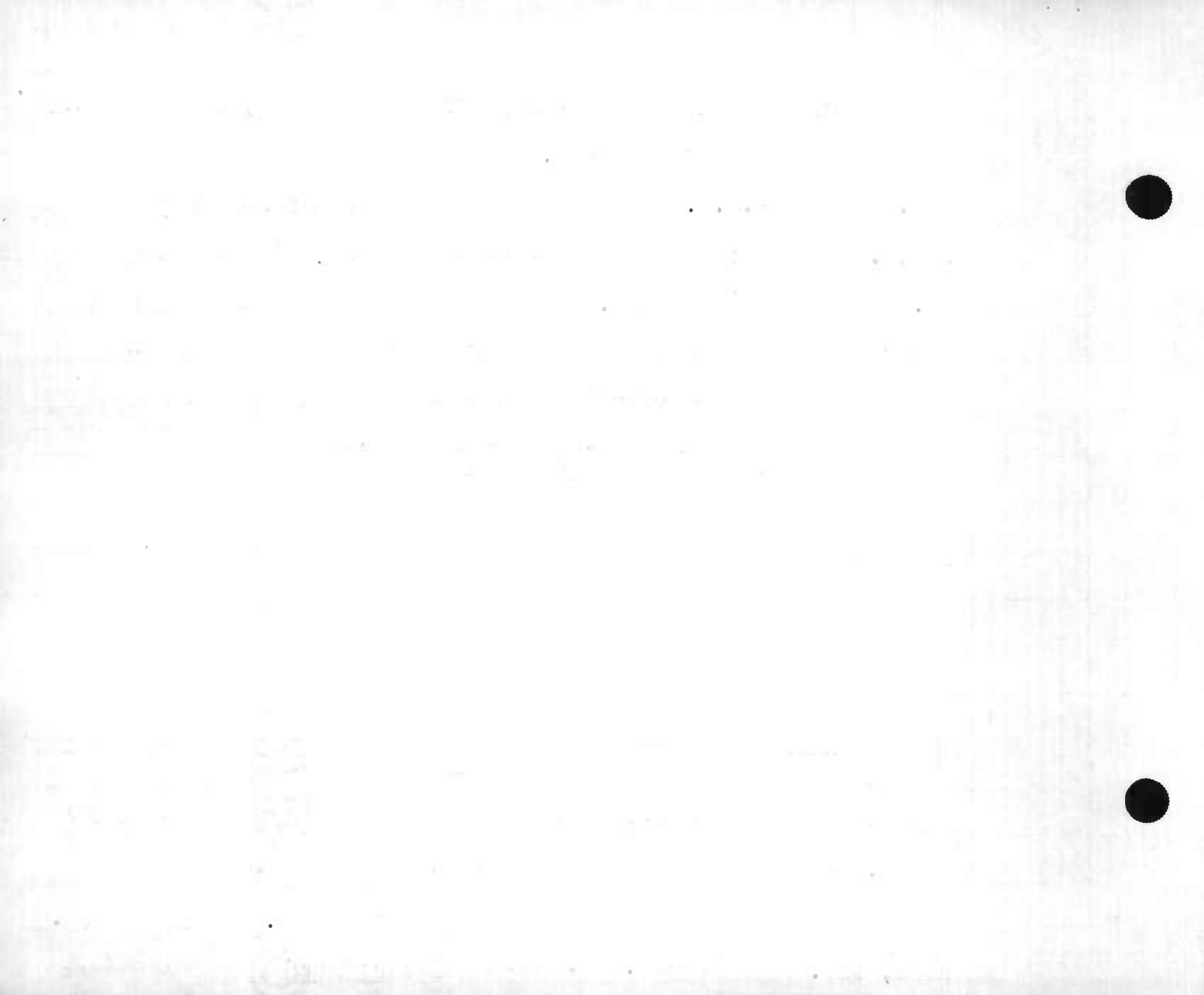
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |  |  |  |   | 8 1 5 0 7 1 1 5                                 |  |
|---|--|--|---|--|--|--|--|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |  | A.  |   |  |
| Mary Helen Jarzynski  |  |  | March 23, 1981  |  |  | 10:45 <sub>M</sub>   |  |  |   |   |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5 DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |   |  |
| Female  |  |  | Caucasian   |  |  | Jan. 10 1890   |  |  | 91 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |  |
| Md.   |  |  | U.S.A.  |  |  |  |  |  | Baltimore City MD.  |   |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |
| Balto.  |  |  | Hamilton Nursing Center   |  |  | Candy Dipper   |  |  | Mary Sue Candy  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |   |  |
| Md.   |  |  |   |  |  | Balto.   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |   |  |
| Frank   |  |  | Josephine   |  |  | no   |  |  | 215-32-9124   |   |  |
| 17. INFORMANT   |  |  | 17. ADDRESS   |  |  | 17. ADDRESS  |  |  | 17. ADDRESS   |   |  |
| Eleanor Lovell (dghtr)  |  |  | same address  |  |  |  |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY   |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>  |  |  |   |  |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |  |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3-15</u> , 19 <u>81</u> , to <u>3-23</u> , 19 <u>81</u> , that (I) (the hospital) last saw the deceased alive on <u>3-20</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  | 22c. DATE SIGNED  |   |  |
| Dr. Marion C. Kowalewski  |  |  | MD  |  |  |  |  |  | 3-24-81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |  |  |  |   |   |  |
| Dr. Marion Kowalewski   |  |  | 8604 Harford Rd.  |  |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |   |  |
| Burial  |  |  | 3/26/81   |  |  | Sacred Heart   |  |  | Balto. Md.  |   |  |
| 24. FUNERAL DIRECTOR  |  |  | 24b. ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |
| Schlimmek Funeral Home, Inc.  |  |  | 3331 Brehms Lane Balto. Md. 21213   |  |  | MAR 27 1981  |  |  | [Signature]   |   |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                              |   |  |  |                                      |   |                 |  |                 |  |  |
|---|------------------------------|---|--|--|--------------------------------------|---|-----------------|--|-----------------|--|--|
| 1. FOR STATE REGISTRAR  |                              | REG. NO. 194 8 05 72 1 1 6  |  |  |                                      |   |                 |  |                 |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |                              | FIRST   |  | MIDDLE   |                                      | LAST  |                 | 2a. DATE OF DEATH MONTH DAY YEAR                               |                 | 2b. HOUR                                     |  |
| ANGELA MARIE  |                              | JASKIEWICZ  |  | MARCH 11, 1981   |                                      | 1:50AM  |                 |  |                 |  |  |
| 3. SEX  | 4. RACE                      |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |  |  |
| Female  | Caucasian                    |   | Oct. 12, 1980  |  | 5                                    |   | MONTHS DAYS     |  | HOURS MIN.      |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |  |                 |  |  |
| Md.   | U.S.A.                       |   |  |  | BALTIMORE CITY MD.                   |   |                 |  |                 |  |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                 | 12b. KIND OF BUSINESS OR INDUSTRY                              |                 |  |  |
| Baltimore   |                              | JOHNS HOPKINS HOSPITAL  |  |  |                                      | Infant  |                 |  |                 |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                              | 13b. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |                                      | 13e. STREET ADDRESS   |                 |  |                 |  |  |
| Md.   |                              | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                      |   |                 |  |                 |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |                              |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                     |                                      |   |                 |  |                 |  |  |
| Thomas Jaskiewicz   |                              |   |  | Diane Paolino  |                                      |   |                 |  |                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |                                      | ADDRESS   |                 |  |                 |  |  |
|   |                              |   |  | Mr. & Mrs. Thomas Jaskiewicz   |                                      | 1011 North Marlyr   |                 |  |                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |   |  |  |                                      |   |                 |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |                              |   |  |  |                                      |   |                 |  |                 |  |  |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>  |                              |   |  |  |                                      |   |                 |  |                 | 2d   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>  |                              |   |  |  |                                      |   |                 |  |                 | 2-4 d  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Liver Failure, Viral Sepsis</u>   |                              |   |  |  |                                      |   |                 |  |                 | 72 min                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                              |   |  |  |                                      |   |                 |  |                 |  |  |
| <u>Liver Failure, C.F. Bleeding</u>   |                              |   |  |  |                                      |   |                 |  |                 |  |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                                      | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |  |  |
|   |                              |   |  |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                      |   |                 |  |                 |  |  |
|   |                              | P.M. 19   |  |  |                                      |   |                 |  |                 |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                      |   |                 |  |                 |  |  |
|   |                              |   |  |  |                                      |   |                 |  |                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> , 19 <u>81</u> , to <u>3/11</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3/11</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |   |  |  |                                      |   |                 |  |                 |  |  |
| 22b. SIGNATURE  |                              | DEGREE  |  |  |                                      | 22c. DATE SIGNED  |                 |  |                 |  |  |
| <u>Richard Scott Lemons</u>   |                              | MD  |  |  |                                      | 3/11/81   |                 |  |                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                              | 22e. ADDRESS  |  |  |                                      |   |                 |  |                 |  |  |
| Richard Scott Lemons  |                              | Johns Hopkins Hosp., Dept Pediatrics  |  |  |                                      |   |                 |  |                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                 |  |                 |  |  |
| Burial  |                              | 3/13/81   |  | Oaklawn Cemetery   |                                      | Baltimore, Md.  |                 |  |                 |  |  |
| 24. FUNERAL DIRECTOR NAME   |                              |   |  | 25a. DATE REC'D. REGISTRAR   |                                      |   |                 | 25b. REGISTRAR'S SIGNATURE                                     |                 |  |  |
| Zannino Funeral Home, 263 S. Conkling St.   |                              |   |  | MAR 16 1981  |                                      |   |                 |  |                 |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

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15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

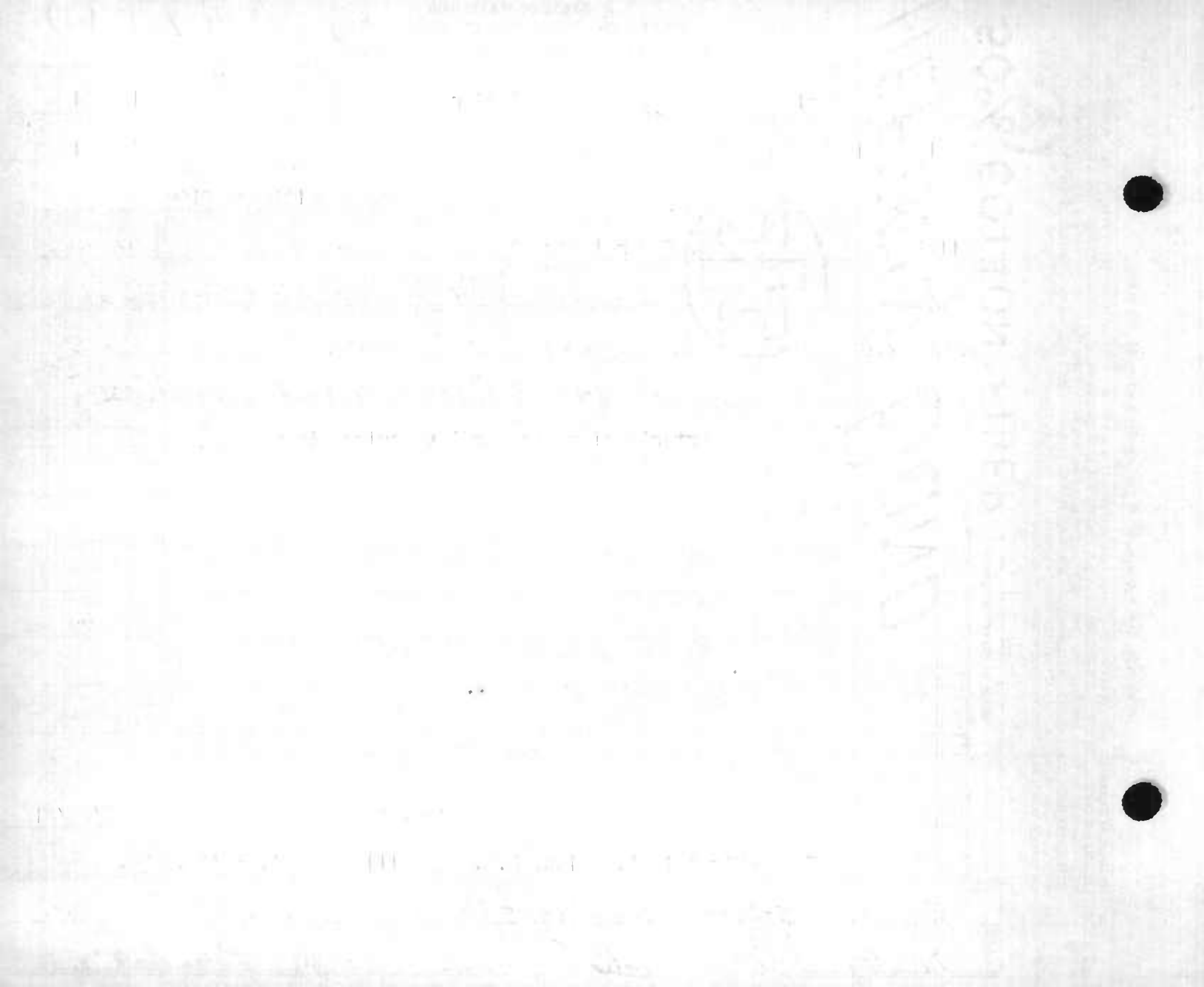
07117

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
|--|--|------------------------------|--|--|--|---------------------------------|--|---|--|------------------|--|--------------------------------------|--|-------|--|--|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST                        |  | MIDDLE   |  | LAST                            |  | 2a. DATE KNOWN OF DEATH   |  | MONTH            |  | DAY                                  |  | YEAR  |  | 2b. HOUR                                     |  |       |  |          |  |
| Merle  |  | C.                           |  | Jeffers  |  |                                 |  | X   |  | 3                |  | 19                                   |  | 81    |  | M  |  |       |  |          |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY  |  | YEAR  |  | 2d. HOUR |  |
| Female   |  | Black                        |  | 6-9-41   |  | 39 YRS.                         |  |   |  |                  |  | 3                                    |  | 19    |  | 81   |  | P     |  | M        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED                   |  | WIDOWED   |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |  |  |       |  |          |  |
| Md.  |  | U.S.A.                       |  | X  |  |                                 |  |   |  |                  |  | Baltimore City, MD.                  |  |       |  |  |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |       |  |  |  |       |  |          |  |
| Baltimore  |  |                              |  | 2828 E. Federal Street   |  |                                 |  | Housewife   |  |                  |  | At Home                              |  |       |  |  |  |       |  |          |  |
| 13a. STATE   |  |                              |  | 13b. COUNTY  |  |                                 |  | 13c. CITY OR TOWN   |  |                  |  | 13d. INSIDE CITY LIMITS?             |  |       |  | 13e. STREET ADDRESS                          |  |       |  |          |  |
| Md.  |  |                              |  |  |  |                                 |  | Balto.  |  |                  |  | YES X NO                             |  |       |  | 2828 E. Federal St.                          |  |       |  |          |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| William  |  |                              |  | Elizabeth  |  |                                 |  | Chase   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  |                                 |  | 17. INFORMANT   |  |                  |  | ADDRESS                              |  |       |  |  |  |       |  |          |  |
| NO   |  |                              |  | 218-80-0453  |  |                                 |  | Clyce Jeffers   |  |                  |  | 2828 E. Federal St.                  |  |       |  |  |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |       |  |          |  |
| PART I DEATH WAS CAUSED BY:  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 4292   |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| (b)  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| (c)  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                 |  |   |  |                  |  |                                      |  |       |  | 20. AUTOPSY?                                 |  |       |  |          |  |
|  |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  | YES X NO                                     |  |       |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  |                              |  | 21b. TIME OF INJURY  |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
|  |  |                              |  | HOUR A.M. MONTH DAY YEAR   |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
|  |  |                              |  | P.M. 19  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 21d. INJURY OCCURRED   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                                 |  | 21f. LOCATION   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| WHILE AT WORK NOT WHILE AT WORK  |  |                              |  |  |  |                                 |  | STREET CITY OR TOWN COUNTY STATE  |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner. |  |                              |  |  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| ACTUAL SIGNATURE   |  |                              |  | TITLE (SPECIFY)  |  |                                 |  | DATE SIGNED   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| Virginia L. Dolan  |  |                              |  | M.D. Assistant   |  |                                 |  | 3/20/81   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                              |  | ADDRESS  |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| Virginia L. Dolan, M.D.  |  |                              |  | III Penn St. Balto., MD.   |  |                                 |  |   |  |                  |  |                                      |  |       |  |  |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION                        |  |       |  | COUNTY                                       |  | STATE |  |          |  |
| Burial   |  |                              |  | 3-24-81  |  |                                 |  | Baltimore Ctry.   |  |                  |  | Baltimore                            |  |       |  | Md.  |  |       |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |  |                              |  | ADDRESS  |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR   |  |                  |  | 25b. REGISTRAR'S SIGNATURE           |  |       |  |  |  |       |  |          |  |
| Randolph J. Collick  |  |                              |  | 2431 E. Oliver St.   |  |                                 |  | MAR 23 1981   |  |                  |  | R. J. Collick                        |  |       |  |  |  |       |  |          |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the body has been taken to the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |                                    |  | 8  | 1 | 0 | 7             | 1   | 1       | 8               |  |       |  |          |  |
|---|--|--|--|--|--|---|--|------------------------------------|--|--|---|---|---------------|---|---------|-----------------|--|-------|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |                                    |  | REG. NO.   |   |   |               |   |         |                 |  |       |  |          |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  |                                    |  | 2a. DATE OF DEATH  |   |   |               | MONTH   |         | DAY             |  | YEAR  |  | 2b. HOUR |  |
| Barbara L. Jenkins  |  |  |  |  |  |   |  |                                    |  | 03/06/81   |   |   |               |   |         |                 |  |       |  | 6:54PM   |  |
| 3 SEX   |  |  | 4 RACE   |  |  | 5. DATE OF BIRTH  |  |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |   |               | IF UNDER 1 YEAR   |         | IF UNDER 24 HRS |  |       |  |          |  |
| Female  |  |  | White  |  |  | May 19 1933   |  |                                    |  | 47   |   |   |               | MONTHS  |         | DAYS            |  | HOURS |  | MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |   |               |   |         |                 |  |       |  |          |  |
| Illinois  |  |  | U.S.A.   |  |  |   |  |                                    |  | Baltimore City MD.   |   |   |               |   |         |                 |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |               |   |         |                 |  |       |  |          |  |
| Baltimore   |  |  | The Johns Hopkins Hospital   |  |  | Housewife   |  |                                    |  | Own Home   |   |   |               |   |         |                 |  |       |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |  |                                    |  | 13d. INSIDE CITY LIMITS?   |   |   |               | 13e. STREET ADDRESS   |         |                 |  |       |  |          |  |
| 13a. STATE  |  |  |  |  |  |   |  |                                    |  | 13b. COUNTY  |   |   |               | 13c. CITY OR TOWN   |         |                 |  |       |  |          |  |
| Singapore   |  |  |  |  |  |   |  |                                    |  | Singapore  |   |   |               | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |         |                 |  |       |  |          |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST  |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |
| Elmer A. Decker   |  |  |  |  | Vreda Codington  |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |   |  |                                    |  | 17. INFORMANT  |   |   |               |   | ADDRESS |                 |  |       |  |          |  |
| No  |  |  |  |  |  |   |  |                                    |  | Sanford S. Jenkins   |   |   |               |   | Same    |                 |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pulmonary embolism</u><br>4530<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Budd-Chiari syndrome</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hours<br>4 months  |   |   |               |   |         |                 |  |       |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |                                    |  | 20a. AUTOPSY?  |   |   |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |         |                 |  |       |  |          |  |
| none  |  |  |  |  | none   |   |  |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |               | YES <input type="checkbox"/> NO <input type="checkbox"/>            |         |                 |  |       |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |               |   |         |                 |  |       |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  |                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |               |   |         |                 |  |       |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 6</u> , 19 <u>81</u> , to <u>March 6</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>March 6</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |  |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |  |                                    |  | DEGREE   |   |   |               | 22c. DATE SIGNED  |         |                 |  |       |  |          |  |
| Nancy E Davidson MD   |  |  |  |  |  |   |  |                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |               | 3/6/81  |         |                 |  |       |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |                                    |  | 22e. ADDRESS   |   |   |               |   |         |                 |  |       |  |          |  |
| Nancy E Davidson  |  |  |  |  |  |   |  |                                    |  | Johns Hopkins Hospital   |   |   |               |   |         |                 |  |       |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE  |   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |   |   | 23d. LOCATION |   |         |                 |  |       |  |          |  |
| Removal-Burial  |  |  |  |  | 3-8-81   |   |  | Memorial Park                      |  |  |   |   | Columbia      |   |         |                 |  |       |  |          |  |
|   |  |  |  |  |  |   |  |                                    |  |  |   |   | COUNTY STATE  |   |         |                 |  |       |  |          |  |
|   |  |  |  |  |  |   |  |                                    |  |  |   |   | Missouri      |   |         |                 |  |       |  |          |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |   |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR  |   |   |               | 25b. REGISTRAR'S SIGNATURE  |         |                 |  |       |  |          |  |
| NAME ADDRESS  |  |  |  |  |  |   |  |                                    |  | MAR 9 1981   |   |   |               | R. J. H. H. H.  |         |                 |  |       |  |          |  |
| Henry W. Jenkins & Sons Co., Balto., Md.  |  |  |  |  |  |   |  |                                    |  |  |   |   |               |   |         |                 |  |       |  |          |  |

MEDICAL CERTIFICATION

RECEIVED  
MAR 25 1981

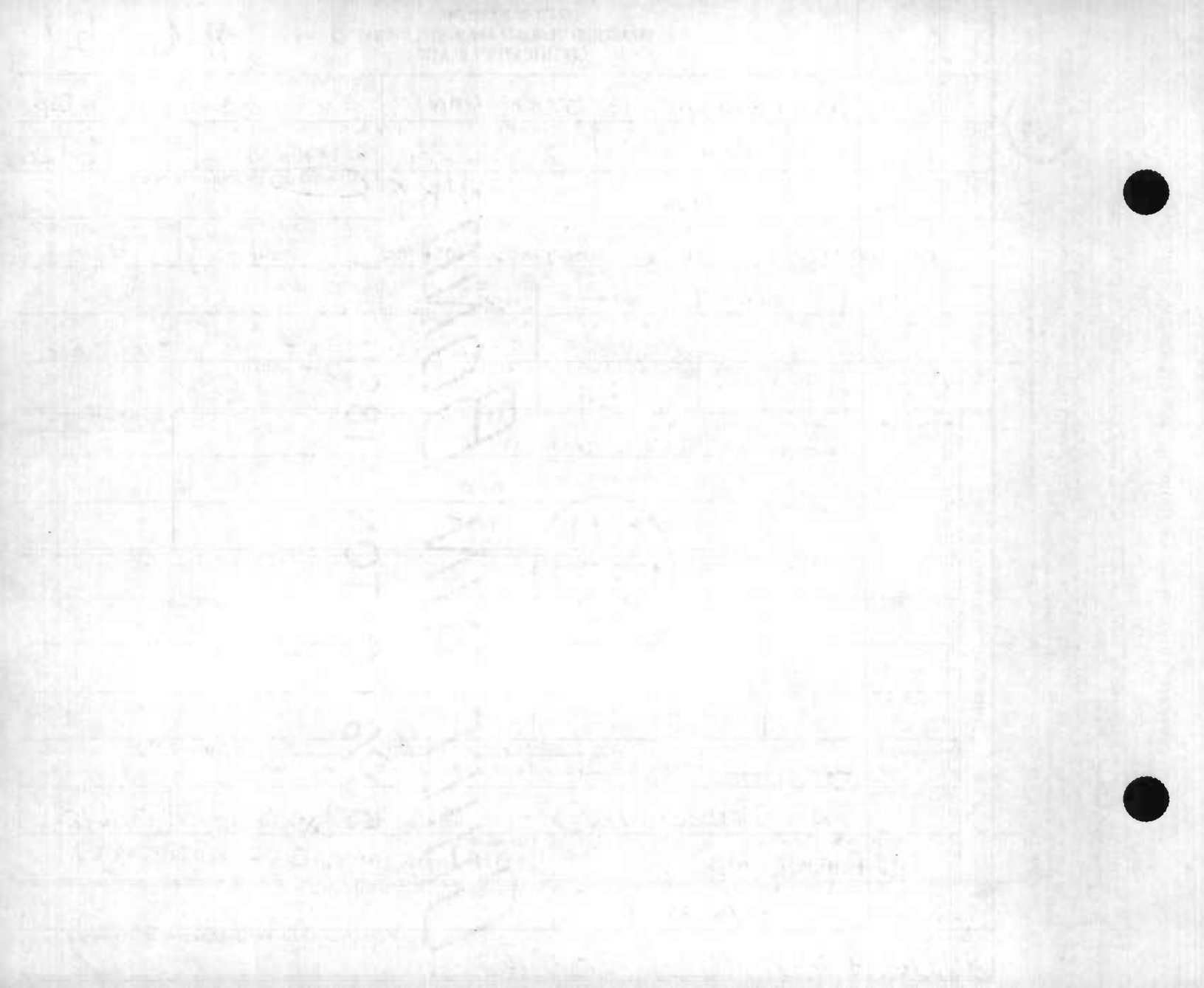
MAR 9 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1  |  | 9-76-029   |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| (BABY GIRL) A JERNIGAN   |  |  |  | 03-16-81   |  | 454 P.M.   |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| FEMALE   |  | BLACK  |  | 03-16-81   |  | ~ 20 MINUTES YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MD   |  | USA  |  | N/A  |  | City MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | UNIV. OF MARYLAND HOSPITAL   |  | N/A  |  | N/A  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d INSIDE CITY LIMITS?  |  | 13e STREET ADDRESS   |  |
| 13a STATE 13b COUNTY 13c CITY OR TOWN  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1825 KAVANAUGH ST.   |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
| 0 NO   |  |  |  | N/A  |  | N/A ADDRESS  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) SEVERE IMMATURITY  |  |  |  |  |  |  |  |
| 7651 DUE TO, OR AS A CONSEQUENCE OF N/A  |  |  |  |  |  |  |  |
| (b) N/A  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF N/A   |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f LOCATION   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16, 19 81, to 3/16, 19 81, that (I) (we) last saw the deceased alive on 3/16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| D. Parker MD   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 3/16/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| D. PARKER MD   |  |  |  | UNIV. OF MARYLAND HOSPITAL   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| REMOVED  |  | 3-19-81  |  |  |  | CITY OR TOWN COUNTY STATE                                      |  |
| 24 FUNERAL DIRECTOR  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR  |  |  |  |
| ANTHONY B.D. of Md.  |  |  |  | MAR 25 1981  |  |  |  |
| NAME ADDRESS   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| BART, MD   |  |  |  |  |  |  |  |

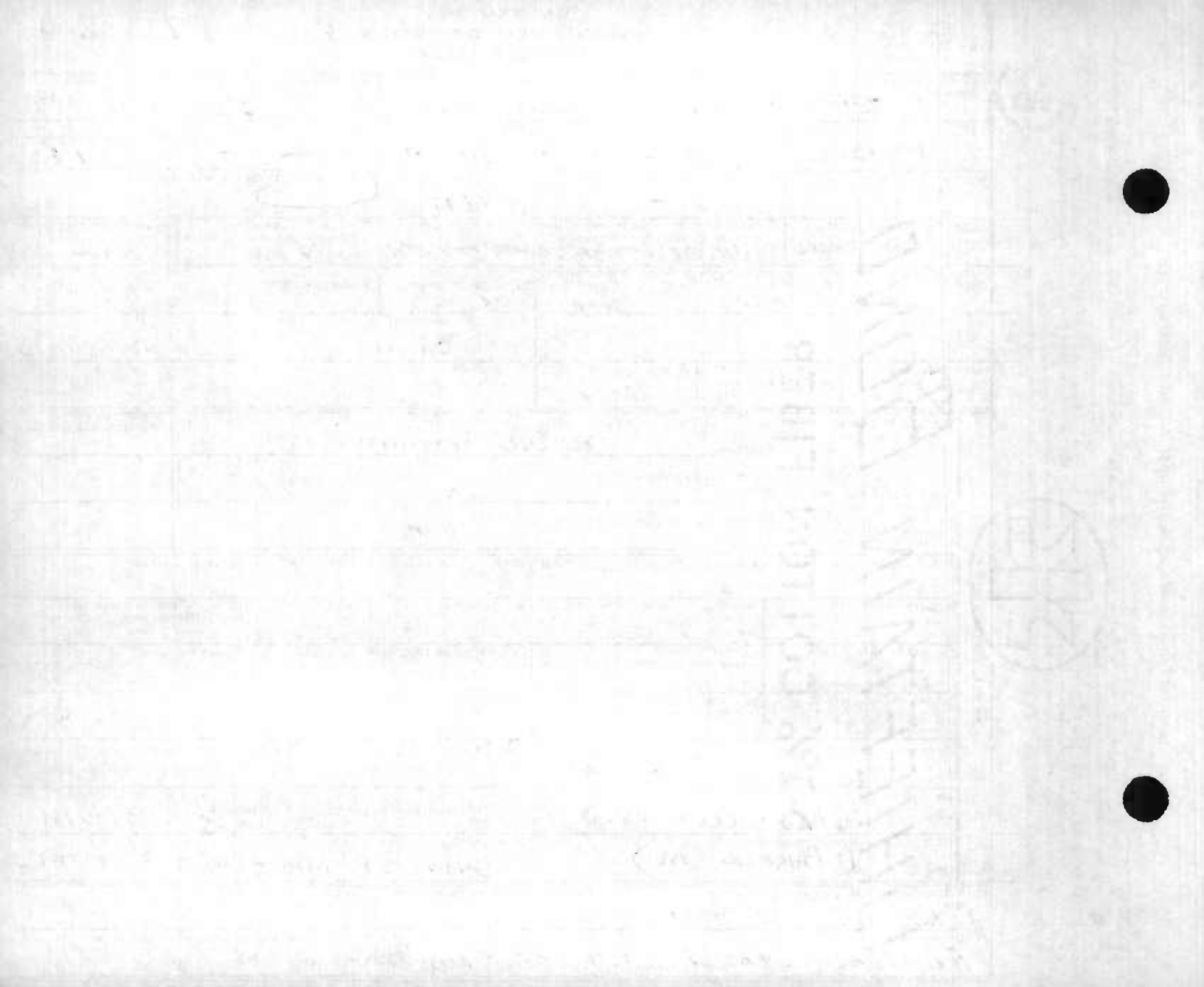


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 1 0 7 1 2 0   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL B JERNIGAN</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>03 - 16 - 81</b> 2b. HOUR <b>9 30 P.M.</b>  |  |   |  |
| 3 SEX <b>FEMALE</b>  |  | 4. RACE <b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>03 16 81</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>1</b> YRS. <b>30</b> MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>N/A</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MD</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <b>UNIVERSITY OF MARYLAND HOSP.</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>N/A</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>1825 KAVANAGH ST.</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>300</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SHIRLEY JERNIGAN</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>0</b>   |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT ADDRESS   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7651</b> IMMEDIATE CAUSE (a) <b>SEVERE IMMATURIT</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>N/A</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>N/A</b>                              |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> , 19 <b>81</b> , to <b>3/16</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>D Parker MD</b> DEGREE   |  |   |  | 22c. DATE SIGNED <b>3/16/81</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D PARKER MD</b>  |  |
| 22e. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL</b>   |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>   |  | 23b. DATE <b>3-19-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>ANATOMY Bureau of Md. Balt. MD</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 23 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |

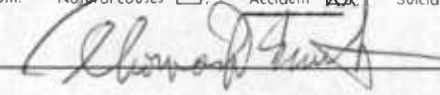





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                     |   |   |  |   |   |   |  | REG. NO. 07121   |  |
|---|--|-------------------------------------|---|---|--|---|---|---|--|--|--|
| FOR STATE REGISTRAR   |  |                                     |   |   |  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Matilda Jeter  |  |                                     |   |   |  |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3 13 19 81  |  |
| 3. SEX<br>female  |  | 4. RACE<br>negro                    |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 10 50   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>30 YRS.   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 13 19 81  |  | 7b. HOUR<br>M<br>6:12 a M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>N.Y.  |  |                                     | 13c. CITY OR TOWN<br>White Plains   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |   | 13e. STREET ADDRESS<br>235 S. Lexington Ave               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Grant  |  |                                     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Selma Guess                     |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br>ADDRESS<br>Henry Jeter 235 S. White Plains NY<br>Lexington Ave. |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Head injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>8120<br>(b)<br>(c)                                |  |                                     |   |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                                     |   |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>4:33 PM 3-13- 19 81  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Driver of auto that struck parked tractor. |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |  |                                     |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>195 north of Aberdeen Md.  |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                     |   |   |  |   |   |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br>   |  |                                     |   | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |   |   | DATE SIGNED<br>3-13-81                                    |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                                     |   | ADDRESS<br>111 Penn St.   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                                     | 23b. DATE<br>3/18/81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Selder Cemetery                            |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Vance, S.C. |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  |                                     |   |   |  | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981              |  | 25b. REGISTRAR'S SIGNATURE<br>                |  |

100% COTTON CLOTH  
THE ELM DOWD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |   |  |   |  |  |  | REG. NO. 07122  |  |
|--|--|---------------|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |               |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST L. MIDDLE C. LAST JETT  |  |               |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 29 YEAR 19 81 |  |
| 3. SEX male  |  | 4. RACE negro |  | 5. DATE OF BIRTH MONTH 7 DAY 20 YEAR 13   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 2b. HOUR 9:35   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD MONTH 3 DAY 29 YEAR 19 81                                    |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1132 Mosher St. |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  | 2d. HOUR p. M.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |               |  |   |  |   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE MD  |  |               |  |   |  |   |  |  |  | 13b. COUNTY Baltimore   |  |
| 14. FATHER'S NAME FIRST Will MIDDLE Jett LAST  |  |               |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST - MIDDLE - LAST -                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)  |  |               |  |   |  |   |  |  |  | 16b. SOCIAL SECURITY NO. 248-28-7984  |  |
| 17. INFORMANT ADDRESS Elouise Bush 1132 W. Mosher St.  |  |               |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>5713 IMMEDIATE CAUSE (a) Cirrhosis of the liver<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |               |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |               |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |               |  |   |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |               |  |   |  |   |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  |   |  |   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |               |  |   |  |   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                           |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |               |  |   |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE [Signature] M.D. Assistant MEDICAL EXAMINER   |  |               |  |   |  |   |  |  |  | DATE SIGNED 3-30-81   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.   |  |               |  |   |  |   |  |  |  | ADDRESS 111 Penn St.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  |   |  |   |  |  |  | 23b. DATE 4/4/81  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park  |  |               |  |   |  |   |  |  |  | 23d. LOCATION CITY OR TOWN Baltimore Co. MD   |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.  |  |               |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 01 1981   |  |
| 25b. REGISTRAR'S SIGNATURE [Signature]   |  |               |  |   |  |   |  |  |  |   |  |



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## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Bo Crystal Johnson</i>                      |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3-21 81</i>   |  |  | 2b. HOUR<br><i>8:30 P.M.</i>   |  |  |
| 3 SEX <i>Female</i>   |  |  | 4 RACE <i>Black</i>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>3 21 81</i>  |  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balt MD</i>                        |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>MD</i>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore MD</i>                                   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hospital</i> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |  |
| 13a. STATE<br><i>MD</i>   |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><i>Bearrett Hardy Kearney</i>               |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Crystal Darlene Johnson</i>  |  |  | 17 INFORMANT ADDRESS<br><i>5109 Chalgrove ave</i>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i> |  |  | 16b. SOCIAL SECURITY NO.<br><i>7651</i>  |  |  | 17 INFORMANT ADDRESS<br><i>5109 Chalgrove ave</i>  |  |  |

## MEDICAL CERTIFICATION

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br><i>7651 IMMEDIATE CAUSE (a) Immaturity</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Immature S.E.A. female abortion</i>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>none</i>   |  |   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>6:15pm 19 81</i> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/21/81 6:15pm 19 81</i> to <i>3/21/81 8:30pm 19 81</i> , that (I) (we) last saw the deceased alive on <i>3/21/81 8:30pm 19 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |

|  |  |   |  |  |  |                                    |  |
|--|--|---|--|--|--|------------------------------------|--|
| 22b. SIGNATURE<br><i>S.M. Williams M.D.</i>                        |  | DEGREE<br><i>M.D.</i>                     |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3/27/81</i> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>S.M. Williams M.D.</i> |  | 22e. ADDRESS<br><i>Provident Hospital</i> |  |  |  |                                    |  |

|  |  |                             |  |                                       |  |   |  |
|--|--|-----------------------------|--|---------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i> |  | 23b. DATE<br><i>3-26-81</i> |  | 23c. NAME OF CEMETERY OR CREMATORY    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Antony Board of Md.</i>     |  |                             |  | ADDRESS<br><i>Baltimore, Maryland</i> |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 27 1981</i> |  |
|  |  |                             |  |                                       |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALL INFORMATION CONTAINED

12-25-81

REMOVED

REMOVED, EXEMPTED

REMOVED, EXEMPTED

MAR 24 1981

*[Handwritten signature]*

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18c G554 4/24/81 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8107124

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|---|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>CLARENCE C Johnson  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>03 25 81 |  |   | 2b HOUR<br>9:30 A M   |  |   |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>N  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>03 04 99  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                       |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH. D.C.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                 |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL |  |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MD 13b COUNTY A.A. 13c CITY OR TOWN CROWNSVILLE 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 940 Johnson LANE |  |  |  |  |   |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John T. Johnson  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH UNKNOWN |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b SOCIAL SECURITY NO.<br>219-01-7126         |  | 17 INFORMANT ADDRESS<br>ELISIE C. JOHNSON 940 Johnson Lane    |   |  |   |  |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>6951 IMMEDIATE CAUSE (a) Congestive Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Acute pulmonary embolism<br>(c) Multiple myeloma erythema |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 03/24 19 81 to 03/25 19 81, that (I) (we) last saw the deceased alive on 03/25 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b SIGNATURE<br>C. Fleischman   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>03/25/81  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MIGUEL FLEISCHMAN  |  |   |  | 22e ADDRESS<br>SOUTH BALTIMORE GENERAL   |  |  |  |

|  |  |                        |  |  |  |   |  |
|--|--|------------------------|--|--|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL      |  | 23b. DATE<br>3-30-1981 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PINELAWN MEM. PARK |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis A.A. Maryland |  |
| 24 FUNERAL DIRECTOR<br>WILLIAM REESE & SONS MORTUARY, P.A. |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981             |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                             |  |



RECEIVED

100 100 100

100 100 100

100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED ON APPROVAL BY MEDICAL EXAMINER

MEDICAL CERTIFICATION

| Items 21a. thru 21f. & 22a. STATE OF MARYLAND  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR Film#G555 5-28-81 at DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOUGLAS-MELVIN JOHNSON</b>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>7</b> YEAR <b>81</b>                          |  | 7b. HOUR<br><b>10:00 PM</b>  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>C</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>9</b> YEAR <b>1961</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>19</b> YES   |  | 7a. UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>1</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md</b>  |  |   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>Johnson</b> LAST <b>Johnson</b>  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Dorothy</b> MIDDLE <b>(Mason)</b> LAST <b>White</b> |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-78-4581</b>   |  | 17. INFORMANT<br><b>Dorothy White 1309 Chapel Street</b>                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Multiple - system failure (Pneumonia)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>95% TBSA Thermal Burn + Inhalation</b>                                |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input checked="" type="checkbox"/> <b>EX</b>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:13 PM 3 7 1981</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>subject in house fire</b>   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET <b>2018 E. Eager Street</b> CITY OR TOWN <b>Balto.,</b> COUNTY <b>BALTO.</b> STATE <b>Md.</b>  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/7</b> 19 <b>81</b> to <b>3/7</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>3/7</b> 19 <b>81</b> , and that (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Accident</b> |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>S. Kanawati</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN APPROVED BY MEDICAL EXAMINER<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3/7/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ISA S. KANAWATI</b>  |  | 22e. ADDRESS<br><b>BCH</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-13-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>BALTO.</b> STATE <b>Md.</b>     |  | 23e. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Brown/Thompson F.H.</b> ADDRESS <b>1913 W. Baltimore St.</b>   |  |   |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 1 2 6

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ERNEST HALBART JOHNSON</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 3 81</b>   |   | 2b. HOUR<br><b>11:53A<sub>M</sub></b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 24</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, LOCH RAVEN, BALTIMORE, MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>2622 WOODBROOK AVENUE 21224</b>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM JOHNSON</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA FINWICK</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   | 16b. SOCIAL SECURITY NO.<br><b>214 18 3286</b>  | 17. INFORMANT ADDRESS<br><b>Mable Bradshaw 2622 Woodbrook Ave</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4920</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>myocardial infarction, severe emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 28</b> , 19 <b>81</b> , to <b>MARCH 3</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>MARCH 3</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Joyce Y. Gross MD</b>  |   | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joyce Y. Gross MD</b>   |   | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD., BALTIMORE, MD 21218</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>3/7/81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1981</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. [Signature]</b>   |   |  |



|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|

RECEIVED  
MAY 19 1964  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 8 1 0 7 1 2 7   |  |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE  | LAST   |
| EVELYN S. JOHNSON   |  |  |   |   |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |  |
| F   |  | N  |   | MONTH DAY YEAR<br>2 15 18   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Maryland  |  | USA  |   | 63 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |
| BALTIMORE   |  |  | ST AGNES HOSPITAL   |   |  |
| 12a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |   | 13b. COUNTY   |  |
| Maryland  |  | Baltimore  |   | 13c. CITY OR TOWN   |  |
|   |  | Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |   |  |
| FIRST MIDDLE LAST<br>Edward Summerfield   |  |  | FIRST MIDDLE LAST<br>Bertha Pinder  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS   |  |
|   |  | 219-07-8252  |   | Henry Hall 3505 Carsdale Avenue   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4700<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASEVD -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular Accident. Post Cardiac Arrest.</u> |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> , 19 <u>81</u> , to <u>3/16</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |
| 22b. SIGNATURE<br><u>Binh T Duong</u>   |  | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>3/16/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BICH THUY DUONG  |  | 22e. ADDRESS<br>900 CATON AVENUE BALTIMORE MD 21229                    |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/20/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pl Arbutus                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MD.   |  | 24. FUNERAL DIRECTOR<br>WM. C. MARCH F/H INC. 1101 E. North Ave.       |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1981  |  | 25b. DATE SIGNED BY REGISTRAR<br><u>[Signature]</u>                    |   |   |  |



BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

ST AGNES HOSPITAL BALTIMORE MD 21202



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |  |   | REG. NO. 07128  |  |
|--|--|--|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Jerome S. Johnson   |  |  |  |  |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>3 18 81                                  |  | 2b. HOUR<br>M                             |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>black                       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-27-24   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                    |   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                 |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 18 81                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1822 Walbrook Avenue |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1822 WALBROOK AVE. |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JEROME S. JOHNSON  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth STARKS        |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-22-6758   |  | 17. INFORMANT ADDRESS<br>Ruth Flood 1825 E. CAPITAL ST. WASH., D.C. |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |   |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br>H. S. Shaw   |  |  |  | TITLE (SPECIFY)<br>Assistant M.D.  |   |   |   | MEDICAL EXAMINER   |   | DATE SIGNED<br>3/18/81  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, MD  |  |  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201   |   |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br>Burial   |  |  | 23b. DATE<br>3/21/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.               |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>DEANON P. Bailey   |  |  |  |  |   | ADDRESS<br>1348 Calhoun St.   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 20 1981             |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.  
JAN 10 1941

RECEIVED JAN 10 1941

*[Handwritten signature]*

*[Handwritten signature]*

1941 U.S. NAVY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at death.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 1 0 7 1 2 9   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| John George Wm. Johnson Sr   |  |  |  | March 5, 1981   |  | M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | Caucasian  |  | April 1, 1910   |  | 70 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md   |  | U.S.A.   |  |   |  | Baltimore City MD   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | 1100 S. Baylis St.   |  | Willan  |  | Alfred Chem   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| Md   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |
| Edward Johnson   |  |  |  | Catherine Johnson   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO   |  |   |  |
| No   |  |  |  |   |  |   |  |
| 17. INFORMANT  |  |  |  | ADDRESS   |  |   |  |
| Mrs. Anne Davis  |  |  |  | 1100 S. Baylis St.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)   |  |  |  |   |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 1629 Congestion Heart Failure  |  |  |  |   |  | 1 year  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |   |  | 15 yrs  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  | 18 yrs  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |
|  |  | P.M. 19  |  |   |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/9 19 69 to 3/5 19 81, that (I) (we) last saw the deceased alive on 11/27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| Francis T. Daly M.D.   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 3/9/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |   |  |
| Francis T. Daly, M.D., P.A.  |  |  |  | 4300 N. Charles St. Balto., Md. 21218   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| Burial   |  | 3.9.81   |  | Calvary   |  | Baltimore Co. Md  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Thomas A. Hoffmann   |  | 3218 Indus St  |  | MAR 9 1981  |  | [Signature]   |  |

1. The purpose of this form is to provide a means for the recording of the results of the performance of the work of the employee.

2. This form is to be filled out by the supervisor of the employee.

3. The supervisor should fill out this form for each employee for whom he is responsible.

4. The supervisor should fill out this form for each employee for whom he is responsible.

5. The supervisor should fill out this form for each employee for whom he is responsible.

6. The supervisor should fill out this form for each employee for whom he is responsible.

7. The supervisor should fill out this form for each employee for whom he is responsible.

8. The supervisor should fill out this form for each employee for whom he is responsible.

9. The supervisor should fill out this form for each employee for whom he is responsible.

10. The supervisor should fill out this form for each employee for whom he is responsible.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |   |   |  |  |   | 8  | 1 | 0   | 7 | 1                              | 3 | 0    |  |          |  |
|---|--|--|---|--|---|---|--|--|---|--|---|---|---|--------------------------------|---|------|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |   |   |  |  |   | REG. NO.   |   |   |   |                                |   |      |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Machel E Johnson</i>   |  |  |   |  |   |   |  |  |   | 2a. DATE OF DEATH  |   | MONTH   |   | DAY                            |   | YEAR |  | 2b. HOUR |  |
|   |  |  |   |  |   |   |  |  |   |  |   | 3   |   | 31                             |   | 81   |  | 3:45 PM  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>Black</i>   |  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 31 20</i>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i>          |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                    |   | IF UNDER 24 HRS.<br>HOURS MIN. |   |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>BALT M.D.</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City -</i> |  |   |   |   |                                |   |      |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALT M.D.</i>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>U. of M.D. Hosp -</i> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>House Wife -</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |   |   |   |                                |   |      |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD</i> 13b. COUNTY <i>BALT</i> 13c. CITY OR TOWN <i>BALT</i>   |  |  |   |  |   |   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   | 13e. STREET ADDRESS<br><i>4306 Fairview Ave -</i> |   |                                |   |      |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Joseph Thomas</i>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Agnes Mills</i> |   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>218-14-9431</i>                      |   |  |  |   | 17. INFORMANT<br>ADDRESS<br><i>George C. Johnson 4306 Fairview Ave.</i>  |   |   |   |                                |   |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIORESPIRATORY ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Tracheostomy &amp; to Vocal cord Paralysis.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Onset of Skull Chordoma -</i>          |  |  |   |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |                                |   |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |  |   |   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 19a. DATE OF OPERATION<br><i>3/19/91</i>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>BASE of Skull Chordoma</i>   |  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |                                |   |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/14</i> 19 <i>91</i> to <i>3/31</i> 19 <i>91</i> that (I) (we) last saw the deceased alive on <i>3/31/91</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |  | DEGREE  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br><i>3/31/91</i>                    |  |   |   |   |                                |   |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Machado</i>   |  |  |   |  | 22e. ADDRESS<br><i>U. of M.D. Hosp -</i>                            |   |  |  |   |  |   |   |   |                                |   |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>4/4/81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arbutus Mem. Park</i>      |   |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. MD</i>  |   |   |   |                                |   |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H</i>   |  |  |   |  | ADDRESS<br><i>1101 E. North Ave.</i>                                |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 2 1981</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |                                |   |      |  |          |  |

SECRET

(M)

SECRET

NO. 100-100000

(S)

SECRET

TOP SECRET



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|--|--|--|--|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  |   | 8 1 0 7 1 3 1   |   |  |  |   |
| CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.  |   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Marion H. Johnson</i>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>3. 19. 81</i> 2b. HOUR <i>4:40 A</i> M |   |  |  |   |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>BLACK</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>1 23 1911</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VIRGINIA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>CITY</i> MD.   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>LUTHERAN Hosp. 730 Ashburton</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>DOMESTIC</i>             |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>BALTO</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1213 Light St BALTO. Md</i>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CHARLES H JOHNSON</i>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARY E. WILSON</i>        |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>218-14-5398</i>   |  | 17. INFORMANT<br><i>Lucy FAUNTLEROY</i>   |   | ADDRESS<br><i>2407 W. OAKDALE ST<br/>Phila. PA 19132</i>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i><br><i>4329</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Intracranial Hemorrhage</i><br>(c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>      |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |  |  |   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/19</i> , 19 <i>81</i> , to <i>3/19</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>3/19</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |   |
| 22b. SIGNATURE<br><i>Lucy Fauntleroy</i> MD  |  |  |  |   | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>3/19/81</i>                                   |  | 22d. ADDRESS<br><i>730 Ashburton St<br/>BALTO. Md.</i>                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal - Burial</i>  |  |  |  |   | 23b. DATE<br><i>3/28/81</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Zion Baptist Church Cem</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Westminster CO. Va</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Chetraw F/H 1701 McLean Balto</i>   |  |  |  |   | 24b. ADDRESS<br><i>Weldow St<br/>Rt 3 - Nomini<br/>Grook, Va</i>              |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 24 1981</i>                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                        |



Handwritten signature

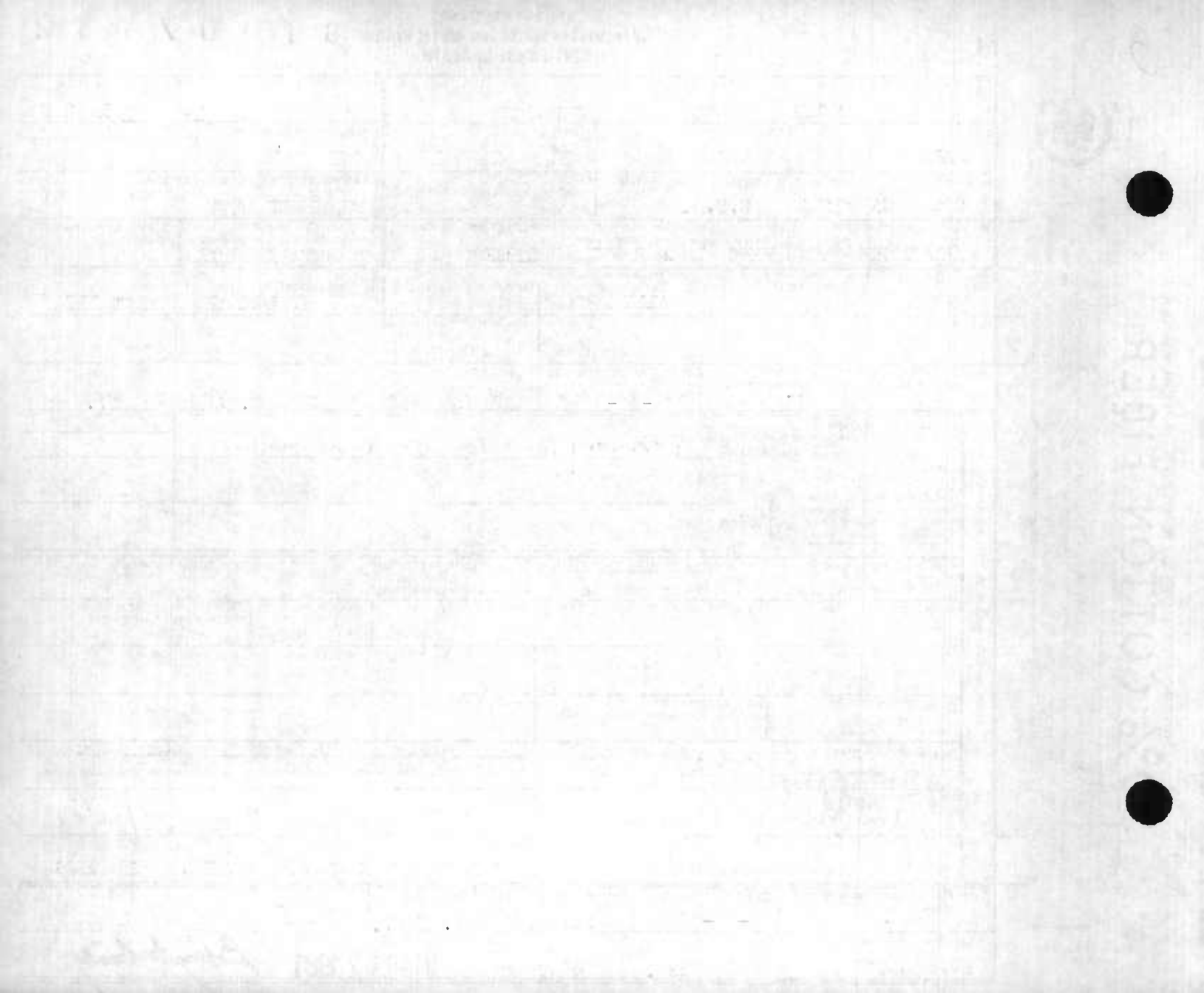
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|--|--|--|--|---|--|--|--|---|--|--|---|---|---|---|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.   |   |   |   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SAMUEL L JOHNSON   |  |  |  |   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 19 81   |   |   |   | 2b. HOUR<br>1:32 P M                                |   |   |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 20 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS                                      |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS<br>HOURS MIN.   |   |   |   |   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>SOUTH CAROLINA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                      |  |   |  |  |   |   |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, LOCH RAVEN, BALTIMORE, MD |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CEMENT FINISHER |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |   |   |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. COUNTY  |  |  |  |   |  |  |  |   |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>2552 W. LOMBARD STREET 21223 |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CONNIE ROBINSON |  |  |   |  |  |   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |  |  | 16b. SOCIAL SECURITY NO.<br>11 248-10-0397  |  | 17. INFORMANT ADDRESS<br>DOROTHY JOHNSON 2552 W. LOMBARD ST.                   |  |   |  |  |   |   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4151 IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS BILAT. MODERATE.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Carcinoma of stomach metastatic to liver + lymph nodes</u>   |  |  |  |   |  |  |  |   |  |  |   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |   |   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |   |   |   |   |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 3</u> , 19 <u>81</u> , to <u>MARCH 19</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>MARCH 19</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |  |   |  |  |  |   |  |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><u>Paul Young-Hyman</u>  |  |  |  |   |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>3/20/81   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PAUL YOUNG-HYMAN  |  |  |  |   |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD., BALTIMORE, MD 21218                     |  |   |  |  |   |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  |  | 23b. DATE<br>3-26-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CHELTENHAM NAT. CEMT.                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CHELTENHAM MARYLAND                   |  |  |   |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>IRVIN CARROLL  |  |  |  |   |  | ADDRESS<br>1712 WEST. NORTH AVENUE   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Helms</u>  |   |   |   |   |   |   |

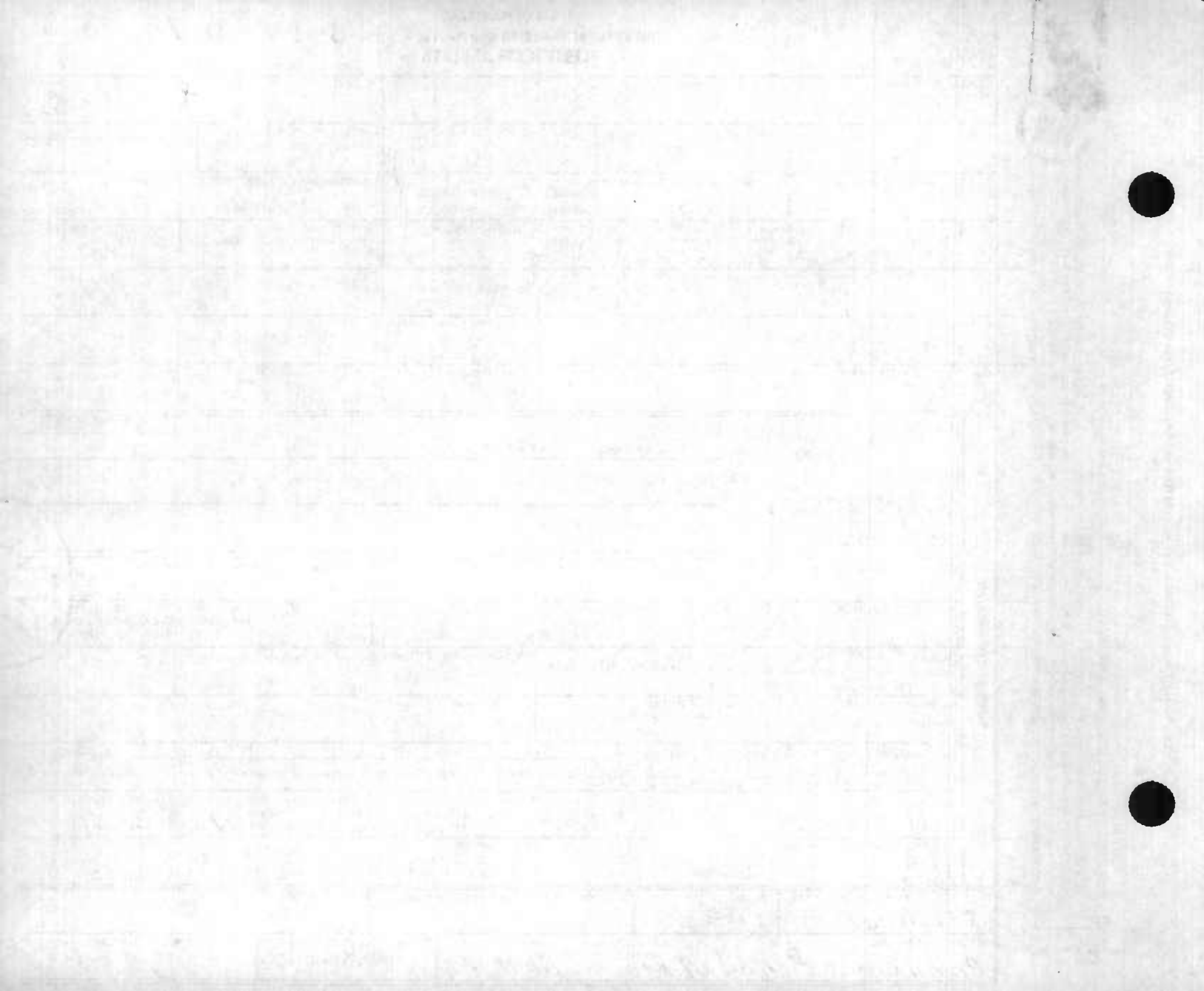


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 7 1 3 3  |  |
|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | REG. NO.   |  |
| BG Jones   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 3 8 81 2 43 AM                                |  |
| 3 SEX F  |  | 4. RACE B  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3 3 81   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 81 MONTHS 5 DAYS 5 MIN.                   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. Md. Hosp. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                        |  |
| 13a. STATE md.   |  | 13c. CITY OR TOWN BALTO.   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Jones  |  | 13e. STREET ADDRESS 701 W. Mulberry  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS 701 W. Lombard St. 21201                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Extreme Prematurity<br>7650<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 3, 19 81, to March 3, 19 81, that (I) (we) last saw the deceased alive on March 3, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |  |  |
| 22b. SIGNATURE William A. Pankey, M.D.   |  |  |  | 22c. DATE SIGNED 3/4/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Pankey M.D.   |  |  |  | 22e. ADDRESS Univ. Md. Hosp. Dept. Pediatrics                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL  |  | 23b. DATE 3-19-81  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 24. FUNERAL DIRECTOR NAME ANATOMY BOARD OF MD  |  | 24b. ADDRESS BOB, MD   |  | 25a. DATE REC'D. BY REGISTRAR MAR 23 1981                                      |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filer, direct to page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1- FOR STATE REGISTRAR  |   | 8 1 0 7 1 3 4  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JAMES EDWARD JONES   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-13-81                                   |  | 2b. HOUR<br>7:55 AM  |
| 3 SEX<br>M male   | 4 RACE<br>B black   | 5. DATE OF BIRTH MONTH DAY YEAR<br>8-20-41   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>39 YRS.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Bn   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL HOSP. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Meislin Transport                               |
| 13a. STATE<br>Maryland  |   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Louis JONES  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CLARA JOHNSON                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Unknown  |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>219-38-2470  |   | 17. INFORMANT ADDRESS<br>(Patient)   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Probable massive aspiration pneumonia<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) undifferentiated carcinoma of the lung<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/4 19 81 to 3/13 19 81, that (I) (we) lost saw the deceased alive on 3/13 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>Barbara A. Cowley   |   | DEGREE   |   | 22c. DATE SIGNED<br>3-13-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARBARA R. COWLEY  |   | 22e. ADDRESS<br>3001 S. Hanover Street, Balto. 21230   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>cremation  |   | 23b. DATE<br>3/16/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.  |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 16 1981   |   | 23f. REGISTRAR'S SIGNATURE<br>[Signature]  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Leroy D. Dyett FH 4600 Liberty Street  |   |  |   |  |  |



35814 MOTO 2.000

MEVOT MATE 1117

Division 10/1/81  
1981



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 0 7 1 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>John A. Jones</u>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>3 / 2 / 81</u>  |  | 2b. HOUR<br>M  |
| 3. SEX<br><u>Male</u>  | 4. RACE<br><u>Blk</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>2-17-1889</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>81</u> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>MD</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>city</u> MD                         |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balto</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>2922 PARKWOOD AVE</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><u>MD</u>  | 13b. COUNTY<br><u>Balto</u>   | 13c. CITY OR TOWN<br><u>Balto</u>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><u>2922 PARKWOOD AVE</u>                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>John A Jones</u>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Ellen</u>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>NO</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>218-10-7751</u>  |   | 17. INFORMANT<br>ADDRESS<br><u>Elizabeth Forrester</u> <u>SAME</u>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><u>1850 IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE - metastatic</u>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>YEARS</u>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/81</u> to <u>3/2</u> , 19 <u>81</u> , that (I) (we) lost <u>saw the deceased alive on above</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Joel H. Cherry, MD</u>  |   | DEGREE  |   | 22c. DATE SIGNED<br><u>3/2/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Joel H. Cherry, MD</u>   |   | 22e. ADDRESS<br><u>200 W Cold Springs Lane 21210</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>  | 23b. DATE<br><u>3/6/81</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. Auburn</u>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto MD</u>                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Vernon R. Bailey</u>  |   | ADDRESS<br><u>1345 W. Calhoun St</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 5 1981</u>                             |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |  |



2009 COLLECTION

W. A. T. T. D.

MAR 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 0 7 1 3 6  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Leman Jones</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/26/81</b>   |  |
| 3. SEX<br><b>m</b>   |  | 2b. HOUR<br><b>1:10 PM</b>  |  |
| 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 7 13</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hosp.</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balt</b> 13c. CITY OR TOWN <b>1</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>elli Jones</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Sears</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>246-07-2072</b>  |  |
| 17. INFORMANT<br><b>Ruth Jones</b>   |  | ADDRESS<br><b>same</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>multiple organ failure</b><br>DUE TO, OR AS A CONSEQUENCE OF *<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pyelonephritis of vesic</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION<br><b>3/15/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>pyelonephritis of vesic</b>  |  |
| 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-19</b> 19 <b>81</b> , to <b>3-26</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>3/26/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Marvin A. Kohn</b> MD   |  | 22c. DATE SIGNED<br><b>3/26/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARVIN A. KOHN</b>   |  | 22e. ADDRESS<br><b>Sinai Hosp.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/31/81</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Vernon R. Bailey</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1981</b>   |  |
| ADDRESS<br><b>1348 N. Calhoun St.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruth Jones</b>   |  |

MEDICAL CERTIFICATION

19

1510 BP



1971 12/21/71  
C. J. J.  
2000 Bell Ave  
West City  
Missouri

mounted again  
superior  
reputation of service

3/12/73 Superior Service

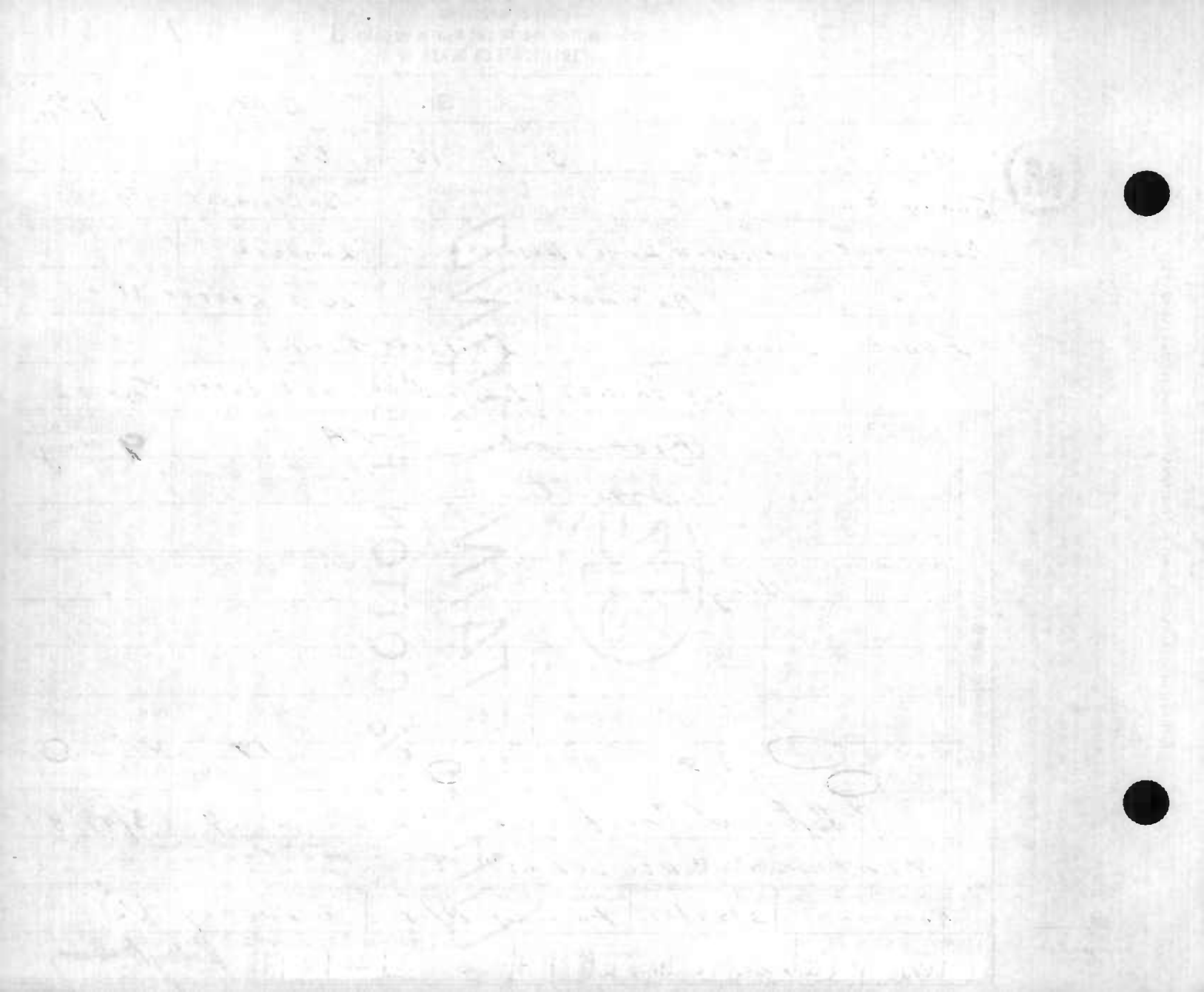
12/1/71  
W. H. A. K. H. A.  
1/1/71  
1/1/71

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |   |  | 8  | 1 | 0 | 7 | 1                           | 3 | 7 |
|--|--|--|--|--|--|--|--|---|--|--|---|---|---|-----------------------------|---|---|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |   |  | REG. NO.   |   |   |   |                             |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MACK JONES SR.</b>  |  |  |  |  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>MAR.</b> DAY <b>3</b> YEAR <b>1981</b>   |   |   |   | 2b. HOUR<br><b>12:40</b> AM |   |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>1</b> YEAR <b>15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |   |   |   |                             |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SURRY VA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                  |  |   |  |  |   |   |   |                             |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |   |   |                             |   |   |
| 13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>26 S. EAGER ST</b>   |   |   |   |                             |   |   |
| 14. FATHER'S NAME<br>FIRST <b>LODIE</b> MIDDLE <b>JUNIOR</b> LAST <b></b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FAIRFAX</b> MIDDLE <b>THOMAS</b> LAST <b></b>   |  |  |  |   |  |  |   |   |   |                             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-70-1173</b>   |  | 17. INFORMANT<br><b>LOUISE JONES</b>   |  | ADDRESS<br><b>26 S. EAGER ST</b>  |  |  |   |   |   |                             |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>(R) VASCULAR ACCIDENT</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>HYPERTENSION</b><br>HYPERTENSION<br>XXXX<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b></b>                |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>  |   |   |   |                             |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Seizure SEIZURE</b>  |  |  |  |  |  |  |  |   |  |  |   |   |   |                             |   |   |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |                             |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)     |  |   |  |  |   |   |   |                             |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |  |   |   |   |                             |   |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>3-9-81</b> to <b>3-19-81</b> , that (1) we lost saw the deceased alive on <b>3-18-81</b> , 19 <b>81</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) did not view the body after death. |  |  |  |  |  |  |  |   |  |  |   |   |   |                             |   |   |
| 22b. SIGNATURE<br><b>Chapman L. Crowder, M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3-19-81</b>  |  |  |   |   |   |                             |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. C. L. CROWDER, MD</b>  |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION</b><br><b>160 N. BROADWAY BALTIMORE, MD. 21231</b>  |  |  |  |   |  |  |   |   |   |                             |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  |  |  | 23b. DATE<br><b>3/22/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Plot</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Waverly VA</b>                                 |  |  |   |   |   |                             |   |   |
| 24. FUNERAL DIRECTOR<br><b>235 N. GILMAN ST</b>  |  |  |  | ADDRESS<br><b>Marshall P. Hayes</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 23 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Marshall P. Hayes</b>   |   |   |   |                             |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 0 7 1 3 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>MARTHA ESTELLE BYE JONES<br><i>MARTHA JONES</i>   |  |  |  | MONTH DAY YEAR HOUR<br>3-16-81 10 <sup>AM</sup>   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | Cauc.  |  | MONTH DAY YEAR<br>8 29 1900   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Maryland   |  | USA  |  |   |  | Baltimore city MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Senai Hosp.  |  | Service Representative  |  | ret.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS?  |  |  |  |
| 13a. STATE COUNTY<br>MD BALT   |  |  |  | 13b. YES NO <input checked="" type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST<br>Dr. Henry H. Bye  |  |  |  | FIRST MIDDLE LAST<br>Clara Bechler  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |
| no   |  |  |  | 218-28-2249   |  |  |  |
| 17. INFORMANT  |  |  |  | ADDRESS   |  |  |  |
| Eileen B. May,   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <i>Cardio/pulm. arrest, Sepsis.</i>  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>perforated ulcers - GI bleed.</i>  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 3/15/81  |  | perforated ulcers  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, HISTORY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER PARTIAL OF INJURY ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-15</i> , 19 <i>81</i> to <i>3-16</i> , 19 <i>81</i> , that (I) (we) lost<br>saw the deceased alive on <i>3-16</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| <i>Marvin Kohn MD</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 3-16-81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |
| MARVIN KOHN  |  |  |  | Senai Hosp.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Burial   |  | 3/19/81  |  | Loudon Park Cemetery  |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  |
| 1630 Edmondson Ave., Catonsville, Md<br>Witzke Funeral Home of Catonsville, P/A.21228  |  |  |  | MAR 18 1981   |  |  |  |





Dr. Henry H. Dym  
 218-28-2249 Eileen S. Dym  
 218-28-2249 Eileen S. Dym  
 218-28-2249 Eileen S. Dym

Cardiac/film. correct, copy  
 printed volume to show

3/12/81 printed volume

W. Lawrence  
 W. Lawrence  
 W. Lawrence

Alaska Funeral Home of Etnahaville, P.O. 22128  
 1828 Etnahaville Ave., Etnahaville, MS  
 London North Cemetery, Baltimore, Maryland  
 3/12/81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

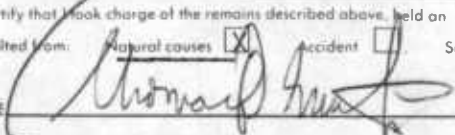

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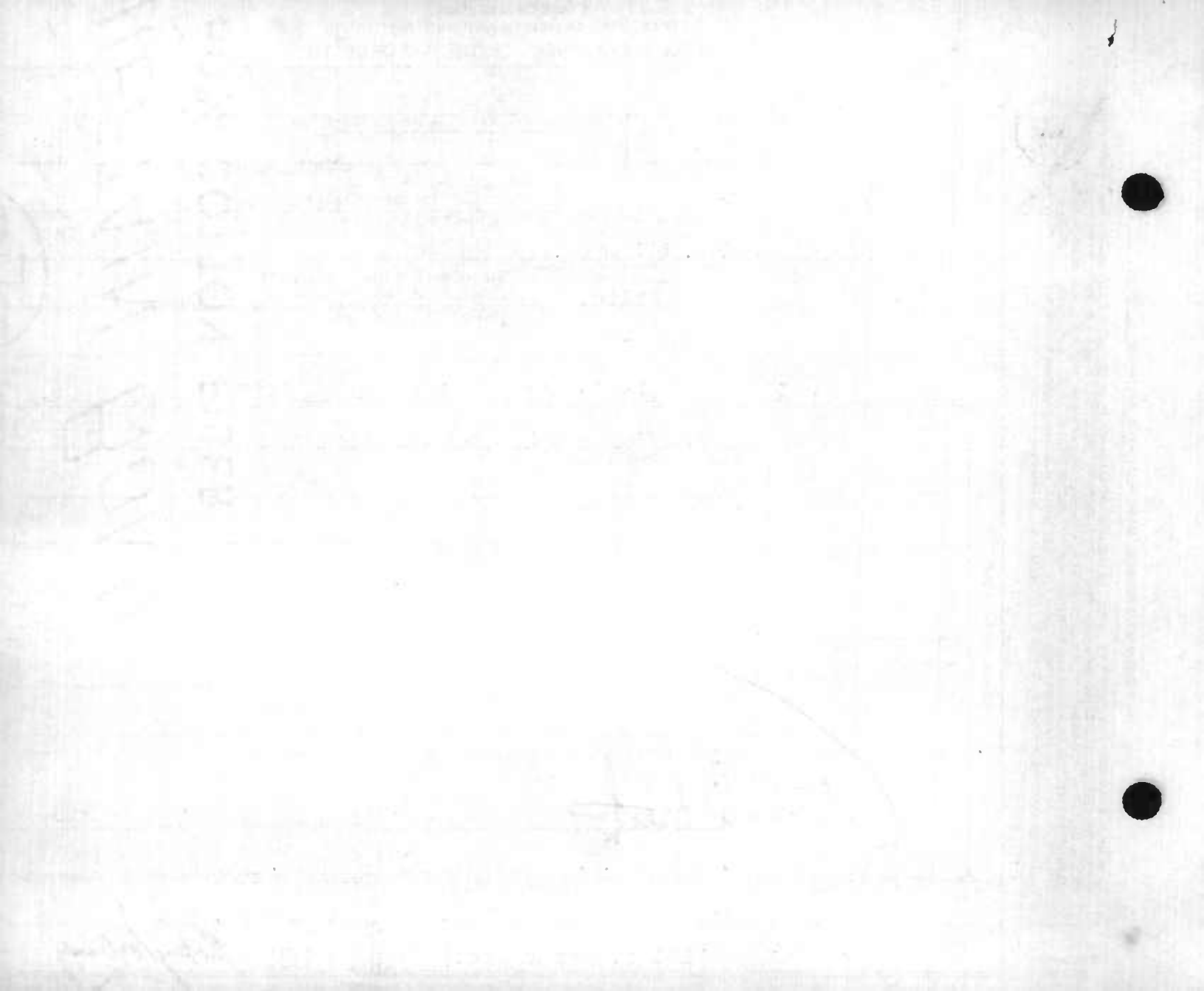
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07139

|   |  |   |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3 12 19 81 |  |   |  |   |  |  |  |  |  | 2b. HOUR<br>M<br>5:14 P   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Winfield Jones   |  |   |  |   |  |   |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 12 19 81  |  | 2d. HOUR<br>M<br>5:14 P                                   |  |  |  |   |  |
| 3. SEX<br>male  |  | 4. RACE<br>negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 17 18 63 YRS.           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN. |  | 7. IF UNDER 1 YR   |  | 7. IF UNDER 24 HRS   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                             |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1627 E. Oliver St. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                         |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |   |  | 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1627 E. Oliver St.                 |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alford Conquest   |  |   |  |   |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Bowley   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII |  |   |  | 17. INFORMANT<br>ADDRESS<br>Helen Jones 1627 E. Oliver St.   |  |  |  |   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?               |  |   |  |  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)     |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |  |  |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br>   |  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief MEDICAL EXAMINER           |  |   |  |  |  |  |  | DATE SIGNED<br>3-13-81  |  |   |  |  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |   |  | ADDRESS<br>111 Penn St.   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>3/18/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.      |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md. |  |   |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  |   |  |   |  |   |  |  |  |  |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 16 1981 |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

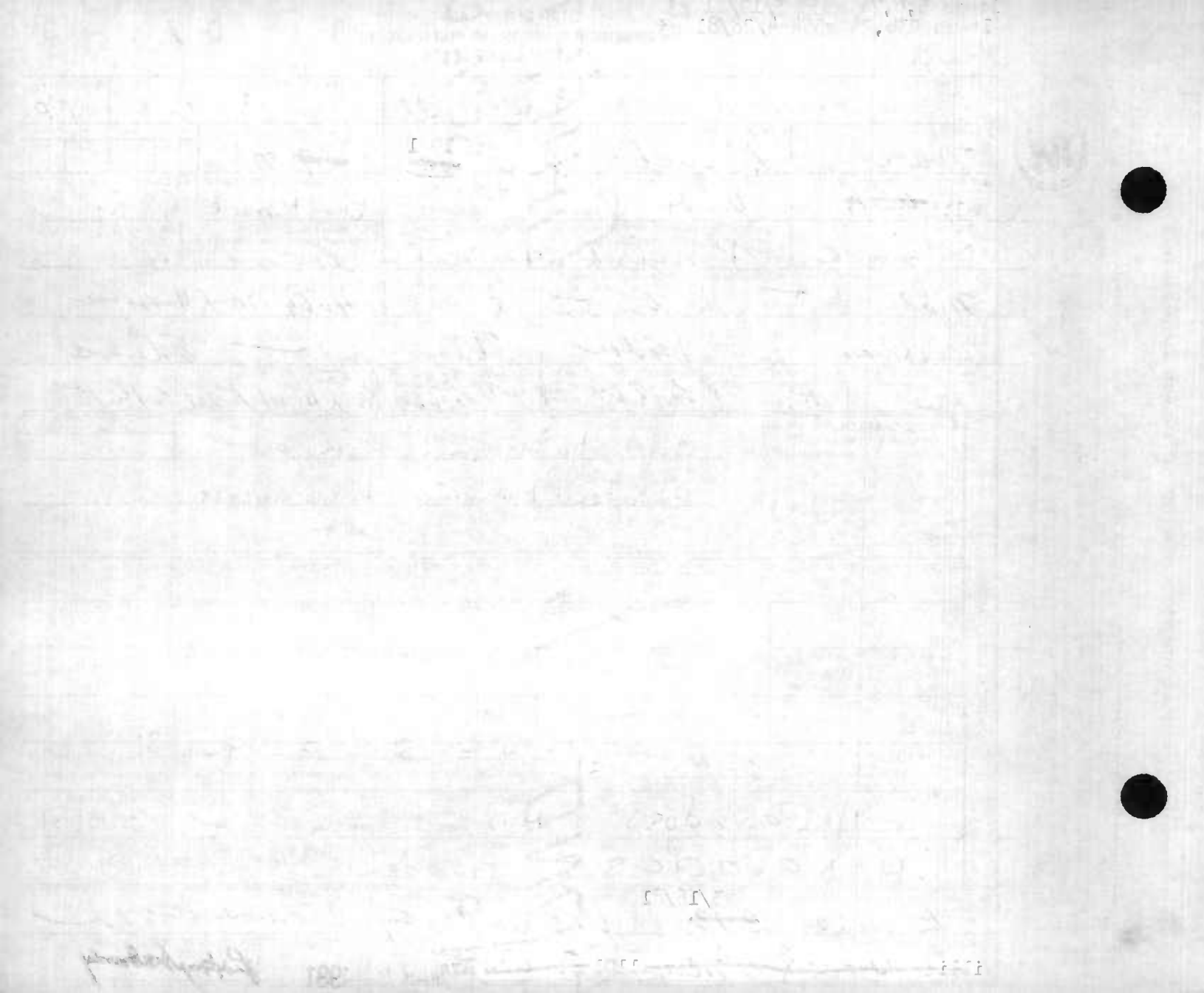


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |   |  |
| REG. NO.   |  |   |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |   |  |
| Bernard  |  |   | Jordan   |  |  | 3-9-81   |  | 2b. HOUR / 10 AM   |   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |   |  |
| male   |  | Black   |  | MONTH DAY YEAR   |  | 37 59 YRS.   |  | MONTHS DAYS HOURS MIN  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |   |  |
| Baltimore MD   |  | USA   |  |  |  | Baltimore City MD  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY                               |   |  |
| Baltimore  |  | Provident Hospital  |  |  |  | Labor  |  | none   |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   | 13b STATE  |  |  | 13c CITY OR TOWN   |  |  | 13d INSIDE CITY LIMITS?   |  |
| md   |  |   |  |  |  | Baltimore  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |  |  | 13e STREET ADDRESS   |  |  |   |  |
| FIRST MIDDLE LAST  |  |   | FIRST MIDDLE LAST  |  |  | 4669 Park Heights Ave  |  |  |   |  |
| Alexander  |  |   | Jordan   |  |  | Clara  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b SOCIAL SECURITY NO.  |  |  | 17 INFORMANT ADDRESS   |  |  |   |  |
| yes  |  |   | 218 09 178   |  |  | 3700 4669 Park Heights Blvd 21215  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and (c))   |  |   |  |  |  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Cardiopulmonary arrest   |  |   |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pneumonia, lung abscess   |  |   |  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CVA.  |  |   |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |  |  |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |
|  |  |   | P.M. 19  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
|  |  |   |  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-14-19-81 to 3-9-19-81, that (I) (we) last saw the deceased alive on 3-9-19-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |   | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |   |  |
| H Devadoss   |  |   | M.D.   |  |  |  |  | 3/9/81   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |  |  |  |  |  |   |  |
| H Devadoss   |  |   | Provident Hospital, Balto.   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |   |  |
| Burial   |  | 3/16/81   |  | Veteran Cemetery   |  | Crownsville MD   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  |  |  |  |  |  |   |  |
| William G. March Funeral Home 1101 E. North Ave.   |  |   |  |  |  |  |  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |  |  |  |   |  |
| MAR 11 1981 [Signature]  |  |   |  |  |  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |  |   |  |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rose B. Jordan  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 7 81                          |   |  | 2b. HOUR<br>M   |   |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 28 10  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1523 McKean Ave. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1523 McKean Ave. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unkn   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Adelaide Dunn                 |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)                 |   | 17. INFORMANT<br>ADDRESS<br>Beverly Brown 1731 Homestead Street                |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Interventricular Heart</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>81</u> , to <u>3/7/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/7/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) not view the body after death.   |  |   |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><u>W. C. March</u><br>1133 PENNSYLVANIA AVENUE<br>SUITE # 200<br>BALTIMORE, MARYLAND 21201   |  |   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   | 22e. ADDRESS   |   |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/11/81   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk.                            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md.                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H   |  |   |  |   | ADDRESS<br>1101 E. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1981  |  | 25b. SIGNATURE<br><u>[Signature]</u>    |  |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78

1967 11 18 AM

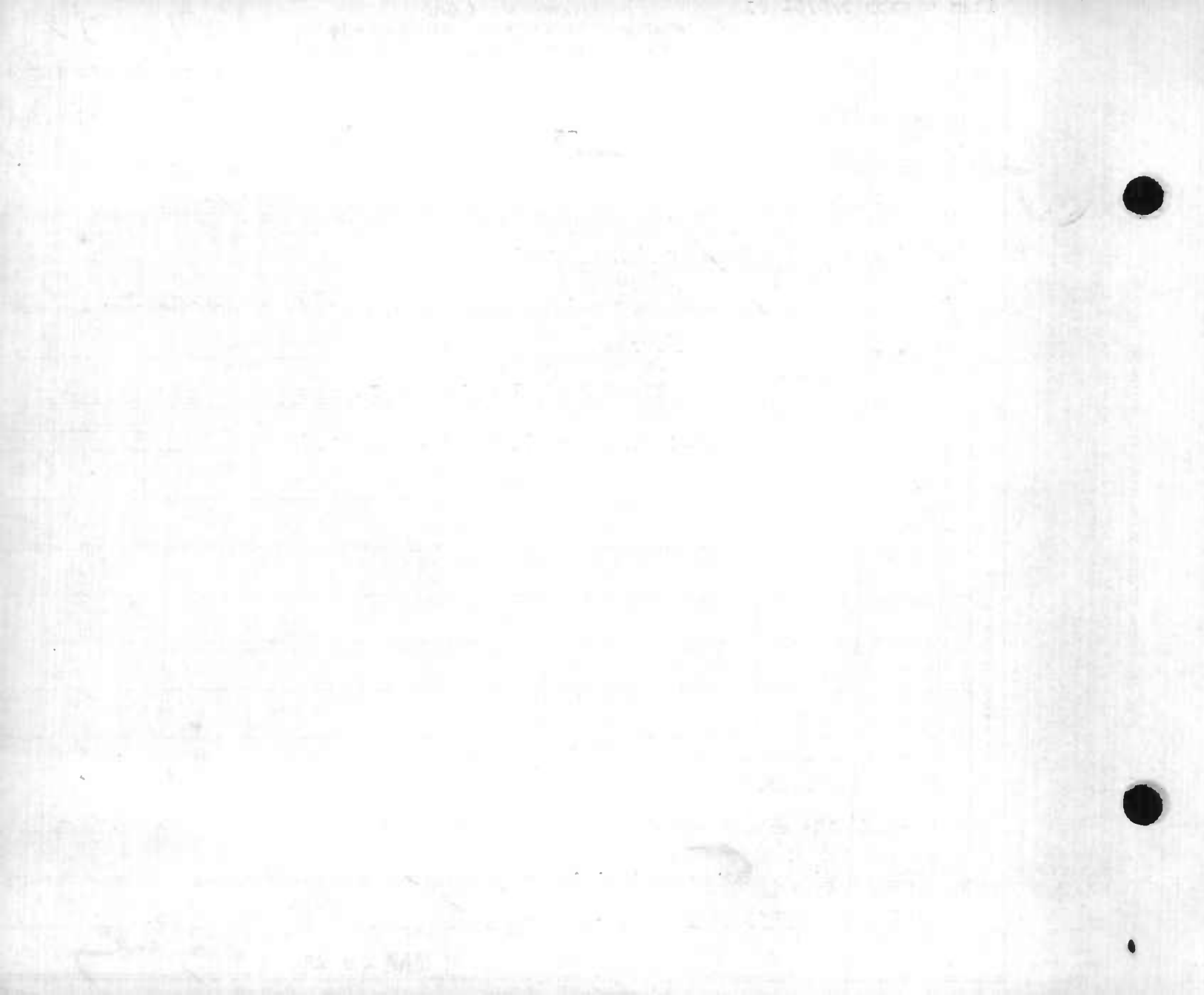


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND; 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |  |  |   |   |  | REG. NO. 07142 |  |
|---|-------------------------|---|---|---|--|--|---|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond R. Joyner</b>  |                         |   |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3 24 1981</b> |   | 2b. HOUR <b>M</b>                               |  |                |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 15 05</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>76</b> YRS.           | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3 25 1981</b>  | 2d. HOUR <b>12:20</b>   |   | <b>A M</b>   |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD.                                 |   |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2700 Presbury Street DOA</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                |  |
| 13a. STATE<br><b>MD</b>   |                         | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   | 13e. STREET ADDRESS<br><b>2700 Presbury St.</b> |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Joyner</b>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva</b>   |  |  |   |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>218-07-9167</b>              |   | 17. INFORMANT ADDRESS<br><b>Lillian Joyner 6254 Cricket Pass</b> |  |   |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |   |   |   |  |  |   |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                         |   |   |   |  |  |   |   |  |                |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |  |   |   | 20. AUTOPSY?<br>(head only)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                            |   |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                           |                         |   |   |   |  |  |   |   |  |                |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |                         |   |   |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>                         |  | MEDICAL EXAMINER  |   | DATE SIGNED <b>3-25-81</b>   |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |                         |   |   |   | ADDRESS <b>111 Penn Street</b>                                   |  |   |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>3/31/81</b>                                 |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem Pk.</b>     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |                         |   |   |   | ADDRESS<br><b>1101 E. North Ave.</b>                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1981</b>                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |  |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH J JUKNELIS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 28 81</b>                         |   |   | 2b. HOUR<br><b>10 AM</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 3 14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Food Manager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>  |  |
| 13a. STATE<br><b>Md</b>   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Juknelis</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eva Bubnis</b>            |   |   | 16. STREET ADDRESS<br><b>15 Hilltop Place</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-05-2856</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Anna A. Juknelis Same as #13</b> |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CORONARY ATHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>? years</b> |  |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DIABETES MELLITUS</b>   |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>3-26-</b> 19 <b>81</b> , to <b>3-28-</b> 19 <b>81</b> , that (I) (we) saw the deceased alive on <b>3-27</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Leon Ashman</b><br>DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   |   |   | 22c. DATE SIGNED<br><b>3-28-81</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LEON ASHMAN</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>5907 GWYN. OAK AVE 21207</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/31/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Witzke Catonsville Funeral Home</b><br><b>1630 Edmondson Avenue Catonsville, Maryland</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 30 1981</b>                                     |  |  |  |

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